Gulstonian Lectures
ON
THE LYMPHATIC SYSTEM AND ITS DISEASES.

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BY JOHN CURNOW, M.D., F.R.C.P.,
PROFESSOR OF ANATOMY IN KING'S COLLEGE, AND ASSISTANT-PHYSICIAN TO KING'S COLLEGE HOSPITAL.

LECTURE III.—PART II.

The Lymphatic System of the Thorax.

THE lymphatic glands in the thorax are best divided primarily into two sets—one on its walls, and the other in the cavity.

The parietal glands are the inferior or diaphragmatic group, from four to six in number, on the convexity of the muscle; two large ones being in front of the pericardium, and the others near the inferior vena cava; an anterior sternal or internal mammary group, eight or ten in number, along the internal mammary vessels; and a posterior or intercostal group, consisting of one or two in the posterior part of each space near the intercostal vessels.

The diaphragmatic glands near the inferior vena cava receive some of the superficial lymphatics of the liver and those deep lymphatics which accompany the hepatic vein, whilst into the sternal glands pass some of the lymphatics of the mamma. The efferent vessels from the diaphragmatic glands pass into the sternal glands, and these in turn go into either the anterior mediastinal or directly into the right lymphatic trunk or thoracic duct. The intercostal efferents pass mainly into the thoracic duct; but those from the highest glands on the right side join with the bronchial efferents to form a bronchio-mediastinal trunk, which is one of the chief tributaries of the right lymphatic duct.

The visceral glands are the anterior and posterior mediastinal, the cardiac, and the bronchial.

The anterior mediastinal are only three or four in number. They are placed amongst the connective tissue in front of the pericardium, and the efferent vessels pass to the right or left main trunks.

The posterior are from eight to ten in number, and lie close to the œsophagus; and their efferent vessels pass into the bronchial glands or into the thoracic duct.

The cardiac glands are in close relation with the large vessels. The largest and most important occupy the space between the bifurcations of the pulmonary artery and trachea. Along the bronchi they are continuous with the bronchial glands.

The bronchial glands, from twenty to thirty in number, are remarkable for their size, black colour, and frequent pathological alterations. Some of them are placed around the free part of the bronchi, whilst others are deeply seated in the hilus of the lung. Into them enter the lymphatics of the lung, and the efferent vessels from some of the posterior mediastinal and cardiac glands and from the lower part of the trachea.

The lymphatic vessels of the thorax may also be divided into parietal and visceral sets.

The parietal groups are the internal mammary, intercostal, and diaphragmatic lymphatics. The internal mammary vessels arise from the under surface of the rectus abdominis muscle above the umbilicus, and as they pass upwards are joined by the most anterior of the lymphatics of the diaphragm and liver, and enter the internal mammary glands. The intercostal lymphatics are generally two in number in each intercostal space, and are placed one on each side of the intercostal vessels.

The lymphatics of the diaphragm arise from both the tendinous and muscular portions, and are of great interest because there is a free communication between the vessels on the thoracic and peritoneal surfaces by means of lymph lacunæ of large size. I shall point out directly, when speaking of pulmonary lymphangitis, that cancerous affections of the pleura may spread through these channels to the peritoneum and *vice versâ*. Four large lymphatic trunks ramify on the muscle; two anteriorly and two posteriorly. The former run to the glands in front of the pericardium, and thence to the internal mammary glands; whilst the latter converge to one of the glands just above the pancreas, from which efferent vessels proceed to the thoracic duct just above its origin. There is a free communication between the anterior and posterior lymphatic vessels by spaces between the fibres of the central tendon. Inspiration must be peculiarly efficacious in filling the lymphatics of the diaphragm, and expiration in facilitating the exit of their contents.

The visceral lymphatics come from the lungs, heart, pericardium, thymus, and œsophagus. Every lobule of the lung, as of the liver and testicle, is surrounded by a lymphatic plexus, and these plexuses may be separated into superficial and deep. The superficial lymphatic networks are found in the subserous connective tissue, and are subdivided, in relation to the lobule, into supra- and circumlobular. The supralobular networks surround the periphery of the lobule. In their normal condition the vessels are of a uniform calibre, and enclose round or oval spaces, but they are frequently found to be varicose, as represented by Mascagni. This is undoubtedly pathological, and is due to coagulation and retention of lymph as a result of the inflammatory attacks, which so commonly affect the surface of the lung. The supralobular capillaries of adjacent lobules freely communicate. They empty into the circumlobular networks, which are arranged with polygonal meshes between the lobules. The vessels which emerge from the networks are arranged into a deep set, which accompany the bronchial tubes and pulmonary vessels to the hilus, and a superficial set whose course is more variable. The superficial vessels, which are the more numerous, arise from the circumlobular networks near the middle of the convex surface of each lobe, and are directed towards the root, some passing over the posterior and some over the anterior border, whilst others pass across the apex. Although mainly subpleural, they may for a variable extent dip down between the bases of the lobules. They communicate freely with the deep lymphatics. Some of the branches from the superficial lobules, however, pass directly to the hilus with the vessels and air-tube.

The deep lymphatics surround the deep lobules, and, like the superficial, are arranged both around the periphery and along the sides of every lobule. They arise from the air-cells by means of lacunæ and of anastomosing canals which accompany the bloodvessels, in many cases surrounding them so as to invaginate them. They run towards the root of the lung, and may be termed, with Klein, the perivascular lymphatics. Their larger trunks are in communication with a second series of irregular lacunæ and anastomosing canals, situate both in the mucous membrane and in the tunica adventitia of the air-tubes. These form in the latter position a network termed the peribronchial plexus; and whilst some vessels first communicate with the perivascular system, others pass direct to the pulmonary glands at the hilus.

The superficial or subpleural lymphatics are directly continuous, as we have before seen with the pleural cavity, by stomata, and the radicles of both the perivascular and the peribronchial vessels are in indirect communication with the alveolar cavities and the surface of the bronchial mucous membrane by means of pseudo-stomata—i.e., not by direct channels, as suggested by Sikorsky and Buhl, but by a connective-tissue cell-plate lying in the alveolar septa, lining, on the one hand, a lymph-canaliculus, and on the other projecting between the flattened epithelial cells of the alveoli.

The pulmonary lymphatics traverse the bronchial glands in the hilus, efferent vessels from which pass to those around the trachea. From these the vessels of the upper half of the left lung open into the thoracic duct near its termination in the neck. From the lower half of the same lung they may pass to the œsophageal rather than to the bronchial glands, and thence into the thoracic duct near its origin. The lower lymphatics of the right lung take a similar course, whilst the upper ones converge to the right lymphatic trunk.

Pulmonary lymphangitis is best studied side by side with lymphangitis of the extremities; the subpleural lymphatic system representing the superficial lymphatics, and the deep intralobular, perivascular, and peribronchial systems the deep vessels of the extremities. The communications between the superficial and deep vessels of the lung are nume-

rous; hence the diseases of the two systems are much more apt to become intermixed than is the case in the limbs. In ordinary cases of simple pleurisy the lymphatics under the pleura are almost always implicated; the vessels are dilated, and they contain a fibrinous exudation similar to that on the pleural surface; lymph-cells and endothelial cells, swollen and undergoing proliferation, are also found therein. These show that the vessels are themselves affected, and that it is not merely an absorption from the pleural cavity. At the same time the lacunar spaces of the subpleural connective tissue become filled with similar elements. In more virulent cases of pleurisy—as, for instance, as a complication of erysipelas—the same phenomena are seen over a much larger extent of surface. In some cases of purulent pleurisy the lymphatics have been found to be dilated and to contain pus, and in these cases also the walls of the vessels are affected. In no case does there seem to be a simple absorption from the pleural sac. In cases of acute lobar pneumonia, the superficial lymphatics are always affected if the disease extends to the pleura. They are filled with an exudation similar in every respect to that which fills the alveoli and covers the pleura. They are very readily recognised in the superficial subpleural connective tissue and in the interlobular tissue. It is very difficult to say what takes place with the deep lymphatics, for they are compressed by the exudation which fills up the bronchioles, alveoli, and infundibula; yet a vascular network in the wall of the lymphatics has been made out by Cornil and Ranvier, so that they doubtless take a large share in the inflammatory process. In lobular pneumonia, which is always accompanied with pleurisy when the lesion affects the surface of the lung, the lymphatics are crowded with large proliferating endothelial cells, lymph- and blood-corpuscles, similar to those in the inflamed alveoli.

It is, however, in the spread of neoplasms, such as tubercle and cancer, that the pulmonary lymphatic system plays such an important part. From a tuberculous spot a chain of granulations, sometimes single, sometimes multiple, has been followed to a bronchial lymphatic gland which has undergone a cheesy degeneration. These granulations are miliary tubercular growths in the wall of the lymphatic vessels. Similar examples have been noticed in the intestines where the granulations have been seen to extend along the lacteals from a tubercular ulcer to the nearest mesenteric glands. In all these cases the cheesy degeneration of the gland evidently denotes that the glandular lesion has preceded the tubercular affection of the vessel, and that it is not a mere propagation of tubercles along the wall of the vessel to the gland. The change in the gland is prior to that in the vessel, for the glands are much more susceptible to irritation and infection than the walls of the vessel. In both tubercle and cancer appreciable lesions of the lymphatic walls are comparatively rare, whilst secondary disease of the glands is of every-day occurrence. So in the case of a simple irritant on the surface, such as an eczematous eruption or a slight burn, the corresponding glands enlarge and become painful before any evidence of lymphangitis can be found, and in many mild cases the wall of the vessels never inflames. Again, if infecting substances circulating in a lymphatic can determine the production of tubercles or of cancer in its wall (as previously mentioned in Andral's case, where there were secondary nodules in the thoracic duct, and in Wagner's cases in the pulmonary lymphatics), it is easy to understand how other parts of the serous surface are contaminated when any one spot is affected by the extension thereto of the primary disease. Cases like the following prove this dissemination of tubercle very conclusively. In subjects otherwise exempt from general miliary tuberculosis, but whose lungs present diverse tubercular lesions which have implicated the visceral pleura, grey granulations have often been seen on the parietal pleura. Sometimes they are found at a point which corresponds exactly to the visceral pleura, but oftener they exist only on the diaphragmatic pleura, disposed circularly around the central tendon of the diaphragm. The richness of the lymphatic plexus in this situation sufficiently explains its being the seat of a special predilection.

In cancer the lymphangitis may be either subpleural or deep, but both forms are not very frequently combined. The former is usually consecutive to cancers of the breast, which extend through the pectoral wall and form vegetations on the costal pleura. On the surface of the lung numerous nodules are found. These vary in size, are radiated in form, and frequently united by anastomosing lines so as to form a large-meshed network. A nodule on the pulmonary pleura is frequently placed directly opposite the primary one on the costal pleura. The form of the network makes it at once clear that the anastomosing lines are lymphatics, and the contents in many places resemble the elements found in the primitive tumour. The lymphangitis is not a simple one, but a lymphangitis terminating in the formation of special tumours. In such cases the primary cancerous mass always extends into and projects on the costal pleura; small actively-growing particles pass into the serous cavity, are taken up by the lymphatics of the pulmonary pleura, and rapidly develop into secondary nodules. Very few or no cancer nodules are found deeply placed in the lungs, and the bronchial glands are not always involved in the disease. Propagation of cancer through the diaphragm by means of the lymphatics takes place in many of the cases in which the pleura or peritoneum is implicated. The tumours on the upper surface are not very characteristic; they are rounded nodules with only occasional prolongations into the adjacent lymphatics; but on the peritoneal surface the white masses always present a radiate appearance, with numerous anastomosing cords which are the lymphatics along which the disease is extending. If it spreads from one surface to the other, the superficial aspect of the lungs on the one hand, or the abdominal viscera which are enveloped by the peritoneum on the other, are found to be studded with scattered tumours. The disease has even passed from one pleura to the other by the intervention of the diaphragmatic lymphatics. This method of dissemination was pointed out by Virchow in cases of cancer of the stomach spreading to the peritoneum; but, in addition to the mere fact of the cancer germs being sown, so to speak, on a fructifying membrane, extension to the viscus beneath the serous membrane where the new growths originate, and changes in the wall of the lymphatics in the vicinity, always take place in a short time, so that the vessel is by no means a passive agent. Moreover, the serous membrane itself becomes inflamed around the new growth.

In the other class of cases, in which the lymphangitis and secondary cancer are scattered throughout the whole depth of the lungs, the course of the malady would seem to have been very different. The primitive disease is a cancer of the stomach or other abdominal viscus, and this is followed by an enlargement of the nearest glands, such as those in the lesser curvature. The disease spreads along the mediastinal glands, which anastomose freely with the preceding until the bronchial glands are implicated. Then the lymphatic vessels of the lung become diseased, and so secondary nodules are found everywhere throughout the viscus, and even the pleura over some of them may be coincidently affected. Cornil has clearly traced a recent simple pulmonary lymphangitis in this way as sequential to a case of syphilitic gummata in the stomach and liver, in which the bronchial and mediastinal glands had undergone extensive chronic change.

The *rôle* of the pulmonary lymphatics in the spread of acute diseases is shown perhaps even still more strikingly in the pleuro-pneumonia of cattle. In the bovine tribe the lobules or ultimate component parts are distinct from each other, and may be regarded as independent lung units, each having its own proper air-tube and bloodvessels, and being connected to its neighbours only by some very delicate connective tissue containing lymphatics. Here and there vessels with a distinct wall are seen; but it is more common to find wide, sacculated, irregular passages, freely intercommunicating one with the other. This interlobular plexus lies midway between two adjacent lobules, and evidently carries some of the lymph overflow from both of them, their lymph-channels being thus intimately related. From these interlobular spaces a thin coloured fluid can be traced into passages in the connective tissue which envelops the large vessels and bronchi, and from thence it finds its way along the main vessels to the root of the lung. There is also a rich set of subpleural lymphatics. Some recent investigations made by my colleague, Professor Gerald Yeo, at the request of the Royal Agricultural Society of England, show most clearly the nature of the morbid changes in pleuro-pneumonia and their pathological sequence. Irritation of the mucous membrane of the smaller bronchi, probably by some infective material (specific virus), leads to a chronic ulcerative bronchitis localised to a few minute bronchi, and occlusion of the affected air-tubes. The peribronchial lymphatics are implicated by the extension of the infective process from the

bronchus, and are soon filled with a dense exudation. The block in the lymphatics of the broncho-vascular system impedes the flow of lymph from the corresponding part of the lung, so that the tributary lymph-channels are mechanically engorged, and at the same time irritated by infective material. The morbid process spreads in two ways. First, by the broncho-vascular lymph-passages. The irritating and infective materials find their way along the lymphatics towards the root of the lung, and the wall of the bronchus after a time becomes affected from its surrounding lymphatics, and as the disease advances the lymphatics of tributary bronchial tubes are choked, their drainage impeded, and the interlobular lymph-spaces of this newly-affected territory filled with exudation. Secondly, by the pleura. This becomes affected over the focus of consolidation by means of the subjacent lymphatics and quickly extends; infective materials now reach the lymphatics beneath the newly-inflamed membrane, and also those between neighbouring superficial lobules, and so extending along the interlobular lymphatics may pass towards the deeper parts, so that an immense tract of lung becomes converted into a semi-translucent mass.

The lymphatics of the heart are somewhat peculiarly arranged. There are two networks—an endocardial and a pericardial, from which rootlets can be traced between the muscular bundles of the bloodvessels supplying the myocardium. These lead into spaces which can be easily injected, so that all the interstices would seem to be lymphatic. The removal of the waste products of a muscle in constant action, like the heart, is thus readily arranged for. The pericardial lymphatics form a large and well-marked network, embracing the two ventricles, and from it two left or anterior, and two right or posterior, trunks pass to the corresponding interventricular groove. The anterior unite into a single trunk, and the two posterior into another, in the auriculo-ventricular grooves. These unite to form a single main vessel, which runs between the pulmonary artery and aorta to a gland near the bifurcation of the trachea. The anterior and posterior vessels anastomose over the apex of the heart. The endocardial network is not so large as the pericardial. The efferent vessels are an inferior set, which emerge at the apex, and join the superficial, and a superior set, which go through the walls near the septum, and also join the superficial lymphatics. The pericardial network is always inflamed in cases of acute pericarditis, and the co-existence of peri- and endo-carditis is doubtless often due to this free lymphatic communication.

The thymic lymphatics are situate in the connective tissue between the lobules, but the relation of the radicles to the lymphoid tissue in the follicles has not yet been clearly traced. The efferent vessels pass to the anterior mediastinal glands. Many cases of lymphatic tumours in the anterior mediastinum take origin in the remains of the thymus.

The œsophageal lymphatics are both mucous and muscular. The former are very numerous, and form a network with elongated meshes in the deeper layer of the mucosa. The efferent vessels join those from between the muscular fibres, and pass into the posterior mediastinal glands.

POISONING BY IODOFORM. — Not much is at present known of the toxic effects of iodoform, and considerable interest therefore attaches to two cases which have been published by Oberlander. The maximum dose given was ·8 gramme daily in a pill. The symptoms of poisoning occurred in one case (a woman twenty-six years of age) after forty-two grammes of iodoform had been taken in eighty days; in the other case (a woman sixty-nine years of age) after five grammes had been taken in the course of seven days. The symptoms produced were giddiness, vomiting, and deep sleep, from which the patient could be roused with difficulty. This somnolence was interrupted by periods of excitement, each lasting several hours, and was followed by delirium, intense headache, sense of impending death, spasmodic contractions of the facial muscles, and, in the case of the younger patient, diplopia. The functions of the other sensory organs were not disturbed, and the pupils presented a normal reaction. Deep inspirations alternated with apnœa of about half a minute's duration. After five or six days the toxic symptoms gradually lessened and passed away.

Clinical Lecture
ON
CASES OF INTEREST OCCURRING DURING THE FIRST TERM OF THIS SESSION IN SOME OF THE LOCAL HOSPITALS.

Delivered at the Cork South Infirmary and County Hospital,

BY PROF. H. MACNAUGHTON JONES, M.D. &c.

(Concluded from page 729.)

Excision of the Ankle-joint and Tarsal Bones.

MANY of you have seen, at the Hospital for Women and Children, a girl from whom I removed the entire tarsal bones and the malleoli in March, 1878. I can now give you but a short sketch of the case. The girl was first admitted in September, 1877, after prolonged treatment outside. She had received an injury, a knock from her brother's boot, some years previously. This resulted in disease of the ankle-joint. She was then attacked with chorea. On admission, she had severe choreic spasms, and writhed at times like an eel in the bed, twisting her limbs into all sorts of contortions. She was treated for the chorea; and the ankle-joint—which, on admission, was considerably swollen, soft, and doughy, with the peculiar pulpy feel of Brodie's degeneration—was placed in a splint of felt, and finally in plaster-of-Paris, these appliances being subsequently changed for iodine pigment and strapping. When I say "Brodie's degeneration," I wish you to understand that I am cognisant of the rare occurrence of this condition, save in the knee; but in every respect my patient's joint presented the signs and symptoms of the disease as pointed out by Sir Benjamin Brodie. She had the peculiar indolent, semi-elastic swelling, involving the entire ankle-joint, giving it, as in the same disease when it attacks the knee, that globular look so characteristic of the affection. Then (as pointed out by Barwell and others) there was the "constant, dull, wearing, gnawing pain." Still, with all this, there was no inflammatory look about the joint, and the foot could be moved and flexed without pain. The total destruction of the bones and cartilages and synovial membrane, as afterwards proved at the operation, exemplified the general termination of this disease—ending as it invariably does in complete disintegration of all the joint structures. Any attempt to dress the ankle-joint brought on a choreic convulsion. I hoped to excise the joint when her general health got better, as she was steadily improving under the treatment adopted for the chorea. But her parents got dissatisfied at the delay, and suddenly removed her from the hospital. In March, 1878, she was brought back to the hospital, conditionally that the limb should not be amputated, which the parents were told ought to be done. I explained how hopeless now the operation of excision might be, and consented to take her back provided the father came to the hospital and permitted amputation if such was deemed necessary. This was agreed to, and she was admitted. The joint was then greatly swollen and red, with a sinus existing at the outer side of the joint. The chorea had ceased, and after keeping her in hospital for about eight days I operated, by one semilunar incision on the outside of the joint, removing the malleoli and also all the tarsal bones. The metatarsal appeared sound. The malleoli were sawn off, the os calcis carefully dissected out, and then the remaining bones removed with gouge, forceps, and knife; no tendon was cut, no vessel was twisted or ligatured. The entire operation was antiseptically performed, and the cavity thoroughly washed out with antiseptic solution. All the usual subsequent antiseptic precautions were employed, and the wound healed kindly. The pulse remained normal; the temperature never rose beyond 98·4°. Various splints were used—side and box splints, felt, plaster-of-Paris, &c. Not to delay you with a subsequent description of the case, I may state how she

now is. Fig. 5 was drawn yesterday from the foot. There appears to be consolidation in the seat of the excised bone. A sinus exists, which is carefully washed out, and the foot is kept on an anterior splint, fashioned like a Thomas's

FIG. 5.

splint, for the ankle. The girl herself is in good spirits, delighted at the ultimate prospect of using her foot, which I trust yet to see under her, but which at one time, I must confess, I had no hope of saving. I may say that so extensive was the disease that, had the father, as I arranged, come to the hospital on the day of operation, the foot would, I am afraid, have been amputated, but, in the faith of my agreement, I refrained.

Excision of a Portion of the Great Trochanter and Shaft of Femur for Femoral Coxalgia.

The little patient, now three years and eight months old, from whom, nearly two years since, I removed a wedge-shaped portion of the femur for necrosis by a longitudinal incision and exsection with a narrow Adams saw, has been brought back to hospital within the past month. He did not return for any surgical affection, but to recruit his health, having suffered from an attack of diarrhœa outside. You saw him walk across the operating-room; both limbs are the same length, and there is only the faintest sign of lameness in his gait. A splendid lesson, teaching us to remove, in this form of the disease, the bone below the capsular ligament, before the joint is implicated. In this case I had aspirated the abscess several times. If aspiration is to be of real use in morbus coxarius, it must be resorted to early, when there is the least sign of fluctuation, and before the bone has become seriously involved. Let me here speak highly of Thomas's hip-joint splint; it is certainly an admirable contrivance for securing prolonged and absolute rest, at the same time that our patient can move about with crutches. But in some cases I am old-fashioned enough to be wedded to the long splint and rest in bed, though I have almost entirely relinquished it for the extension method of Sayre and the weight and pulley. There are always cases under treatment by this method in our little children's hospital, and then you can see for yourselves the good results obtained.

Excision of the Hip-joint.

There is still in hospital, and, I am happy to say, with some prospect of recovery, a little girl, aged seven years, operated on September 23rd, 1877, for extensive acetabular coxalgia. The diseased acetabulum and a large portion of the femur were removed. The case has been fully alluded to elsewhere, so I will now merely say that she is putting on flesh, the constitutional symptoms that threatened her having, if not passed away, greatly subsided, the site of the wound and of the old sinuses is healthier, and though a terrible case for months, I now do not despair of a favourable issue. She is one of three of the same family who suffered from morbus coxarius; one died of constitutional disease nearly one year after the operation of excision, the third recovered completely after treatment by early aspiration and extension and the evacuation of a considerable quantity of pus from the tissues outside the joint. This family history, I believe, clearly indicates the occasional purely constitutional origin of this disease.

Tenotomy for Contracted Knee-joint, and Forcible Extension; the propriety of excision in certain cases of knee-joint disease.

There have been during the past few months three most instructive cases of disease of the knee-joint in the Children's Hospital. Briefly, the histories are as follows:—

J. B——, aged twelve, an intelligent boy, fell on the knee-joint about four years and a half since; this was followed by inflammation, swelling, sinuses, &c. No strumous history in family. He was admitted to hospital on Oct. 12th, with the joint in good position, little or no pain, but considerable swelling, and the remains of several old openings, one situated about two and a half inches above the inner condyle, discharging very slightly; another on the head of the tibia, also slightly discharging. The boy was perfectly healthy in every other respect; his appetite was good; he walked fairly on the limb; on the affected side the foot was on the same plane as the other. My first impression was excision. You saw him with a Thomas's splint on. With this he has gone home, and it has already relieved him. I did not excise this joint, inasmuch as I should have taken away the epiphyses of the joint to remove the disease; and, secondly, I would prefer in such a case, so long as other symptoms did not demand it, to give the patient a reasonable chance of recovery of his limb, without resorting to so formidable, and in his case deforming, a step as excision.

J. H——, aged six years, was admitted to hospital a miserable delicate child. After a fever twelve months ago he fell on the knee, and since that time the joint had become diseased. When admitted the heel nearly touched the buttock, so contracted was the joint. Sinuses had formed about the joint; two opened above the condyles, and one below the head of the tibia. He had suffered great pain outside, but of late this had gone. The knee was for a few months in this contracted state. I decided to nourish the child first and restore his general health. He looked a fair case for excision; but the bones were extensively implicated, and the age of the child deterred me. I resolved to try gradually to extend the limb. This I was assisted in by a splint contrived by my friend Dr. T. G. Atkins, my clinical assistant at the hospital. Extension was made and maintained by a screw, which worked on the thigh and calf portions, these latter being connected by a hinge. With this I was enabled to make gradual extension and thus to bring the

FIG. 6. (*a*)

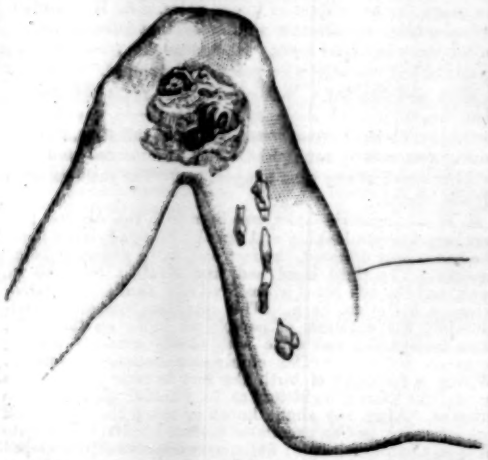
(*b*)

leg down to the angle shown in the drawing (Fig. 6, *b*). In the *British Medical Journal* of the 4th of last

January you will find the figure of an apparatus made by Mr. Heather Bigg for Mr. Erichsen, which commends itself to us for the ingenuity and simplicity of the design. It was used by Mr. Erichsen in a case of contracted knee, caused by the bite of a panther, with perfect success. Such an appliance I hope in due course to employ for the next case I allude to. I have since divided the biceps subcutaneously, and forcibly straightened the joint. The little fellow is going on well, and the limb is quite straight. Very little inflammation followed the operation, and I trust (with Mr. Hilton) to prolonged rest yet to save his limb without excision. About a year since I published in THE LANCET ("Mirror of Hospital Practice") a case in which I performed tenotomy of all the hamstrings for contracted knee-joint, with a large abscess, which at the same time I aspirated and hyper-distended with carbolic solution as used by Mr. Callender. That child has perfectly recovered, and is now running about at home in the country.

The third case has only quite recently been admitted. The patient came into hospital with his leg as shown in the drawing. (Fig. 7.) I found on examining him that a sinus

FIG. 7.



extended from the popliteal space to the gluteal region, in the cellular tissue of which there was a large bag of pus. The boy had a temperature of 101° and a rapid pulse. He was extremely emaciated, having suffered with his limb for nine months. Abscesses had been opened outside. The mischief began by a twist of the joint (a history rather of Hey's luxation). He had been on a trapeze, had a fall, gave his knee a twist, fell fainting to the ground, when a bystander, by forcibly extending and pulling on the leg, set him so far right that he was enabled to get on to the trapeze again. From this time there was a long history of inflammation and abscess. But the bone appeared to have escaped, the chief mischief being in the soft textures about the joint. Finding that pus was concealed here and there I determined to open up all the sinuses, and thoroughly antisepticise the wounds, at the same time to divide the hamstring tendons, and endeavour to get the limb into a better position. I operated on the second day after his admission to hospital. I found that pus had gravitated here and there in pockets and false canals in the cellular tissue from below the popliteal space to the gluteal region. Some of you saw the large number of sponges which could be packed into the cavity in the thigh. The external popliteal nerve lay exposed for over three inches of its course; the popliteal vessels were quite near. I pointed out to you the posterior ligament of the joint. Subcutaneously at the inner side I divided the semi-membranosus, and at the outside cut the biceps, but it was impossible to bring the limb more than moderately down without danger to the nerves and vessels. All was thoroughly antisepticised; the dead tags of skin were cut away, the cavity well cleansed, the entire being conducted under the steam spray. A carbolised sponge was stuffed into the cavity in the side of the joint. Suffice it for the present to state that he is doing well; the wound is looking healthy. No pus has formed since the operation; he has had no pain; his temperature has not been over 99°; his general state is vastly improved, and I hope yet for a successful issue.

Tracheotomy.

I have had one case at the Children's Hospital. I performed the operation late at night on a child brought to the hospital with impending apnœa from pressure on the larynx in a case of adenitis and some accompanying cervical cellulitis. The little patient, aged five months, was a badly nourished child, and had been ill for some days; the mother said the swelling had come on suddenly, and the great dyspnœa had lasted two days. There was no exudation in the throat. With my colleague, Dr. Grattan, present, I opened the trachea readily. The tubes I had to hand, those I now show you, were large for the size of the trachea, and I had to enlarge the wound in the direction of the cricoid cartilage. This is the only case of tracheotomy I have ever had any difficulty in, and it is a lesson to be provided with a small tube, such as those of Jessop's, which are perfect for very young children. I tried a Durham's vertebrated tube with a trocar, but this also was too large, and produced dangerous apnœa in endeavouring to insert it. I got, however, after some trouble, a small tube in; there was some hæmorrhage, and the blood got into the trachea, which, perhaps foolishly, I sucked out with my mouth (though I was certain the case was not diphtheritic). The child was immediately relieved by the operation; the swelling subsided. On the third day after the operation bronchitis set in and inflammation of the lungs, and the child died.

I would advise you all to read the discussion on Mr. Parker's cases of Tracheotomy in Diphtheria, brought before the Royal Medical and Chirurgical Society some weeks since, in which he lays special stress on the after-treatment in tracheotomy, and the careful withdrawing of all false membrane after the tube is opened. Of Mr. Callender's flexible tubes, though so highly spoken of, I have no experience. In adults I prefer the instrument of Mr. Durham. I would advise those who would master the etiology and treatment of laryngo-tracheal diphtheria, to read the recent treatise on this subject by Dr. Morell Mackenzie. The fatal mistake with regard to this operation in a surgical sense is that, as a rule, it is performed too late; the reputation of the operation suffers by the timidity of friends and the hesitation of the operator.

Extreme Retroversion of the Uterus, with Hydatids.

The most interesting gynæcological case we have had was that of a woman admitted with retention of urine and distended bladder, uncertain of pregnancy. She had a few months since a flooding outside, and had had six previous pregnancies. She was an enormously fat woman, with a pendulous abdomen, which made the abdominal examination extremely difficult; there was no reaching the os uteri. A large tumour pressed the rectum posteriorly; the bladder could only be emptied with a long elastic catheter. Suddenly, after a few days in hospital, a severe flooding came on, and she passed a quantity of hydatids. She went home shortly after for the Christmas holidays, and is now attending my colleague, Dr. W. J. Cummins, under whose care she was first admitted.

Necrosis of the Lower Jaw in a child aged seven years.

My colleague, Dr. N. Grattan, removed the entire half of the lower jaw for this disease in a little boy who is now discharged. Some of you saw the operation. The occurrence of necrosis in so young a child is uncommon. Its origin appeared to be carious teeth. Though the operation was not antiseptically performed, the incision healed by primary union, and the little patient speedily recovered.

Colles' Fracture and Luxation of the Joint.

During the recent frost we have had an unusually large number of patients with this variety of break. I now show you three of these attending here this day, all recovering. In each you see there is no deformity. I now show you a cast taken some time since here of a hand with an old unreduced Colles' in a man, and here a drawing taken in this extern department about the same time of a Colles' fracture fourteen days after the accident unreduced; also a drawing of an arm with the well-known and characteristic signs of this fracture immediately after the occurrence. Dupuytren denied *in toto* the occurrence of luxation of the wrist-joint. But since his

time a number of surgeons have placed authentic cases on record. I have met one, and, as is usual, attended with fracture. I cite it for you as it is the only case in which I ever had any permanent deformity in Colles' fracture of moment.

Some years since, after a lecture to the anatomical class in college was over, a student, anxious to see a part I had been demonstrating, a rush being made, thought to outstrip the others by vaulting from his seat over the barrier. I saw him spring, and come with his whole force on the bench of wood, which gave way, and he fell with terrible violence on the ground. His hand had saved his head, but on raising him up I saw there was a most unusual deformity. The hand appeared foreshortened, the carpus projecting, with a great sulcus posteriorly. My first impression was that it was a case of simple luxation of the hand forwards, but on examination I immediately detected crepitus. This was considerable, and the fragments appeared comminuted. He was at once seen by the late Professor J. H. Corbett, under whom I then acted as demonstrator. He agreed with me that it was a dislocation forwards of the carpus, with Colles' fracture and fracture of the ulna. We readily reduced the luxation, the hand returning into its proper position, and remaining there; the usual deformity of Colles persisted. We then set the fracture. Suffice it to say that, notwithstanding all care, a deformity, not considerable, remained.

In this instance, with the comminution there was probably some impaction of the fragments. Now, you are all aware, for we have often spoken of them, of the various assigned causes of the deformity of this fracture, described by the great Dublin surgeon. You see me treat it, contrary to some of the plans recommended in many works, with two straight splints, broad, well padded, a short anterior splint to the wrist, with a good pad over the lower end of the upper fragment, and in the situation of the pre-existing swelling; a long posterior splint, straight to the ends of the fingers, not necessarily hollowed out for the hand. You see I am most careful in reducing the deformity thoroughly at first, and in keeping up forcible extension all through the dressing. Unless there is pain or swelling, I am not in a hurry to disturb these dressings for a few days. I then look at the limb and now put it up to disturb it as little as possible until osseous union has taken place. For the experience of others in the employment of Nélaton's "pistol splint," the boat splint of the distinguished surgeon in our own university, Professor Gordon, of Belfast, as also the splints of the American surgeons, Hamilton, H. Hewitt, E. P. Smith, Bond, &c., drawings of which I show you, I refer you to your various text-books, but I would advise you all to peruse carefully the chapter in that unrivalled work on "Fractures and Dislocations," by Dr. Frank Hamilton, of New York, dealing with this subject.

And now, gentlemen, I have in a very imperfect manner recapitulated for you some of the most important cases coming under my treatment and observation during our first term. I have chosen this subject in order to urge the large class of students attending here—as you are studying in a provincial town of comparatively small size, with scattered opportunities of observing disease — to make the most of those opportunities, and visit not one or two, but all the hospitals which are open to you, special or other. Thus, and thus only, you may hope to fit yourselves for a future practice of your art, and gain a knowledge of the different branches of your profession, a profession in which science is daily adding to the store new facts as rapidly as "the sparks fly upwards."

THE Oystermouth Local Board and Urban Sanitary Authority, Glamorganshire, have reduced the salary of the medical officer of health to £15 per annum, and he has resigned in consequence, stating that he could not, in honour to his profession, discharge the duties for so small a sum.

ROYAL COLLEGE OF SURGEONS IN IRELAND.—From the annual report it appears that during the year ending 5th April last 6 candidates obtained the fellowship, 106 the licence in surgery, and 10 the diploma in midwifery. The examiners for the latter subject have not a very lucrative post, as we find that the fees divided among the three amounted to only £8 13*s.* 3*d.* The total receipts for the year were £5993 9*s.* 6*d.*, and the expenditure £6226 16*s.* 11*d.*, or a balance of £233 7*s.* 5*d.* overdrawn.

NOTES ON UNUSUAL OR RARE FORMS OF SKIN DISEASE.

BY TILBURY FOX, M.D., F.R.C.P.,
PHYSICIAN TO THE DEPARTMENT FOR SKIN DISEASES IN UNIVERSITY COLLEGE HOSPITAL.

IV.—CONGENITAL ULCERATION OF SKIN (TWO CASES) WITH PEMPHIGUS ERUPTION AND ARREST OF DEVELOPMENT GENERALLY.

MISS E. H——, aged six years, and her sister, Miss H. H——, aged two years and three months, were brought to me in February, 1874, suffering from a very unusual and remarkable affection, which I think is of sufficient interest to be recorded.

The father and mother of the children were perfectly healthy, as far as could be ascertained, and they apparently came from a healthy stock. No syphilitic or strumous taint could be made out in their family history. There had been six children from the marriage. A. H——, the eldest, aged eight years, is living and healthy. E. H——, aged six years, is the subject of these notes. B. H—— died, suffering from an affection similar to that to be described, on the sixth day after birth. He had no skin from his knees upwards, but was otherwise properly developed. C. H—— is alive and healthy. H. H—— is two years old, and is also the subject of these notes. D. H—— is alive and healthy. These children were all born at full time, and the mother was well up to the last. She experienced no fright or other shock at any time to upset her. The children were all wet nursed.

E. H——, aged six years, was born with this disease, and was very delicate-looking and small. She had, when born, the hands only diseased, the feet and body generally being healthy. The right hand had, first of all, a bulla on its back, and the left hand a *dark-red sore* similarly situated, where a bulla had been. This condition was *quickly* followed by the outbreak of pemphigus bullæ on the body, some transparent, and some with bloody contents, leaving sores on bursting. The child soon became emaciated. Within a fortnight of birth the feet became bad like the hands, but there is no history as to whether the soles were affected. After any slight knock or touch the skin would rub off easily, and an excoriated surface be left. This state of things became chronic; bullæ were occasionally developed in the mouth, and the fingers gradually contracted and became deformed.

When I saw the little girl, she was slightly emaciated; the sensibility of the skin was unimpaired, and here and there on the surface was a bulla. The whole skin of the forehead was thinned and shining, as if a simple inflammation had been followed by decided atrophy; the nose was sunken at the root; the eyes were weak; the teeth late in development, atrophied, but not decayed; the tongue bound down to the floor of the mouth, and there were white patches along the gums; the skin of the arms was shrivelled slightly, as if xerodermatous, that of the elbow almost ichthyotic; the hands looked as if strumously inflamed and deformed, the backs tense and shining, the knuckles prominent and enlarged, the fingers cramped together, the finger structures dense, the nails gone, and the whole aspect claw-like. There *had* been distinct ulceration. Both hands were similarly affected, and there was still considerable movement left. The thighs were dry and almost ichthyotic; the legs like the arms; the feet dry and scaly and *webbed together from the healing of adjoining raw surfaces*, but the feet were not otherwise distorted; the nails were absent. On the buttocks were the remains of bullæ, and some places were thickened and scaly.

H. H——, aged two years and three months, was also born with evidences of bullæ on the body, and this kind of eruption has continued in some degree ever since. When seen by me she was a weakly child, and unable to walk. She had just cut an eye-tooth, and had all but the molars; but whilst teething, the general development of the body seems to have been retarded. On examination the throat was found sore and ulcerated; the tongue blistered—indeed, a large bulla which appeared the night before had left a slight ulceration; the body looked as if blotched all over

with fading psoriasis, and the skin was thick and stained; the sole of the foot was the site of a warty patch from the root of the toes to the heel; the nails come and then fall rapidly, at present there being none on either hand, and, indeed, with the exception of one on the little finger, no nail has grown for two months. On the toes she had nails till six months old, and since then none have remained permanently. With regard to the bullæ, she is sometimes quite free, but at other times isolated bullæ appear here and there on different parts of the body, and notably in those situations where the skin may be rubbed by any chance. Before these outbreaks the friends noticed that for a week at a time the little patient was very irritable, waking up every ten minutes from sleep, and complaining of intense itching.

Remarks.—I think, if I recollect rightly, that it is stated in the *Edinburgh Medical Journal* for 1877, in reference to cases like the above, that *congenital absence of the skin*, partial or complete, has been noticed by accoucheurs from the time of Hippocrates; and that, if partial, cicatrisation takes place and the child may live; if complete, a fatal termination results. Generally this skin defect is connected with other conditions of malnutrition. The cases I record were *congenital*, and there was general atrophy and arrest of development of the body in connexion with the diseased state of the skin. The bullæ, I take it, were only an evidence of the perverted innervation of the skin, and did not constitute the real malady—the congenital defect of skin tissue. The disease was not syphilitic, certainly. I find Mr. Hutchinson (Path. Soc. Trans., 1875) records, under the head of "An unusual scar-leaving eruption in a young infant, accompanied by other symptoms, and followed by general arrest of development," a case which seems like those I have described, but I think the disease is different from "sclerema neonatorum." I think, instead of making a new variety of disease out of such cases, they should be classed with ichthyosis, under the head of congenital malnutrition of the skin. At a recent meeting of the Clinical Society of London, Dr. Crocker exhibited a case recently under my care in University College Hospital, in which there were several scars resulting from congenital ulceration of the scalp and leg, together with warty and horny growths all over the body in some cases resembling ichthyosis.

TWO CASES OF SPINAL SCLEROSIS.

BY JAMES McMUNN, L.K.Q.C.P.I.,
LATE ASSISTANT PHYSICIAN, SLIGO AND LEITRIM HOSPITAL FOR THE INSANE.

THE following notes of two cases of spinal cord disease may, perhaps, be considered worthy of perusal by those who were interested in the communications in THE LANCET of July 27th, 1878, by Dr. Buzzard, particularly relative to the patellar reflex tendon test for locomotor ataxia.

The subjects of the diseases were two lunatics resident in the Sligo and Leitrim Hospital for the Insane, but the mental aberration was not in either case such as to interfere with a full inquiry into the physical complications. They were both men, and their ages were respectively fifty-six and thirty-seven years.

K——, aged fifty-six, admitted September, 1876, suffering from acute mania. Of intemperate habits. Married, eight children, and the subject of a peculiar affection of locomotion, in which he was inclined to fall forward, and from a general muscular debility. By occupation a labouring farmer. The history is that he was healthy up to about one year ago, when the first symptom of the paralysis came on, and consisted in a weariness in the lower extremities after a hard day's work, and a feebleness, which gradually developed into an inability to ascend or descend a staircase. Unusual exertion also brought on a tremulous condition, which at times was so violent as to cause him to fold his arms with the idea of mitigating it. Next he experienced some difficulty in retaining the contents of the bladder. Symptoms of disordered cerebral function set in at this time—giddiness, headache, &c.,—which soon culminated in an attack of mania, for which he was admitted. After a time the mania subsided and he relapsed into a state of moral insanity, while the paralytic condition steadily increased without corresponding mental disorder.

Sept., 1878.—Configuration stout; aspect dull; intellect good, memory being scarcely impaired; only evidence of insanity an unkindly feeling towards his friends. Digestive system normal. Has not perfect command over his bladder. Locomotion much impaired; can walk badly without support, and inclines forward irresistibly, and when not supported often runs in an awkward manner, as if to prevent his tumbling forward. Nevertheless, he can follow a straight line tolerably well, though shutting his eyes unsteadies his gait. He drags his toes along the ground, and seems unable to elevate his feet sufficiently. The muscles are of normal bulk, generally very firm, but particularly those of the legs. Muscular power is diminished, with the exception of a powerful resistance, especially in the knee-joint, to flexion and extension; there is no fibrillation. Spasms, generally jerking in character, frequently occur, unaccompanied by unusual pain. The only diseased phenomenon connected with the nervous system in reference to the disorder is that the cutaneous surface presents, particularly in some regions (along the spine and over the patella), a slightly diminished sensibility, as tested by the æsthesiometer, although, on deep pressure, some pain is complained of in the lower dorsal region, and the slight amount of anæsthesia referred to was probably more due to a dull cerebral receptivity than to implication of the cutaneous sensory nerves in the cord. As regards the special senses there is slight atrophy of the optic discs. The pupils of both eyes are very much contracted. Hearing and the other senses normal.

These symptoms led to the diagnosis of "antero-lateral sclerosis of the cord." The absence of symptoms dependent on irritation of the spinal sensory nerves, and the character of locomotion, dismissed the idea of locomotor ataxia. The history of the case, absence of pain, and other symptoms, negatived meningitis, myelitis, or allied affections. The gradual progress of the physical, without a proportionate—or, indeed, any—advance in the mental condition, the part of the body affected, the intact state of those muscles primarily and principally affected in general paralysis, and absence of the generally accompanying delusions, showed it could not be that disease. After a time the disease became worse, so that it was then at first sight difficult to see anything characteristic about his gait, and to an observer for the first time it might appear ataxic, as well as, or instead of, powerless.

The second case was as follows:—H——, admitted Dec. 1877, affected with monomania and a paralysis which was at a glance suggestive of locomotor ataxia. His monomania consisted in exaltation of ideas,—he fancied he was a general. Memory was impaired slightly, otherwise the intellect was fairly good, nor did he suffer from hallucinations or illusions. The countenance was rather dull and expressionless. The body was well nourished, and the muscles large but flabby. Locomotion was ataxic—i.e., he walked with his legs much apart, while the heel came first and forcibly in an unsteady manner to the ground, with the toes everted (looking at the ground whilst walking helped to steady the gait of this patient, while the first patient could not attempt the act at all were he to look at the ground without falling). He could not walk in a straight line. True paralysis was wanting. Giddiness came on when the eyes were shut. There was commencing paralysis of the bladder and sphincter ani. The patient himself described accurately the symptoms resulting from irritation of the spinal sensory nerves; thus he had shooting electric pains in the legs, and a feeling of alternate heat and cold in the same limbs (though now sensitive to those agents), and formication at first, and, latterly, as disorganisation increased, anæsthesia to a considerable degree supervened, for he was unable to distinguish with his naked feet a carpet or mat from the boards, or feel when the soles were tickled. There were atrophy of the optic discs and diplopia; also a feeling of constriction round the waist.

Whilst in the first patient's case slight dysæsthesia over the spinal cord, and anæsthesia, as referred to, were present, only paræsthesia and anæsthesia were well marked in this case, with the accompaniments of locomotor ataxia. Hence the diagnosis was easy without employing Westphal's test—a test I was not aware of then. About this time I had the pleasure of showing the two cases to Dr. C. Bucknill, who at first sight thought that both might be locomotor ataxia, judging from their gait, but his lucid mind at once suggested a means of diagnosis in the patellar reflex tendon test. The leg of the patient who suffered from locomotor ataxia did not hop, nor was the foot jerked in the least when the tendon

of the patella was struck with varying degrees of force, while that of the other patient jerked *immoderately* on a slight stroke below the patella.

The man suffering from locomotor ataxia died suddenly some time afterwards (October, 1878), and an autopsy revealed the characteristic lesions of that disease. The other patient is still alive, and almost in the same condition as described.

Gower-street, W.C.

A CASE OF SYPHILITIC INOCULATION BY A TOOTH-BRUSH.

BY E. BUCHANAN BAXTER, M.D., F.R.C.P.,
PROFESSOR OF MATERIA MEDICA AND THERAPEUTICS IN KING'S COLLEGE, LONDON; PHYSICIAN TO THE EVELINA HOSPITAL FOR SICK CHILDREN; ASSISTANT PHYSICIAN TO KING'S COLLEGE HOSPITAL, ETC.

A. B——, a healthy-looking boy of three, was brought to me on the 3rd of April last, at the Blackfriars Hospital for Diseases of the Skin, on account of an eruption that had made its appearance on the belly a few days before, and had spread rapidly to other parts. On stripping him I found the body covered with a well-marked secondary syphilide of the papular kind. The distribution of the rash was symmetrical; it was limited to the trunk, the skin over the limbs and head being quite clear. The tonsils were swollen, and the fauces reddened, but not ulcerated. On the dorsum of the tongue there was a circular erosion as big as a hempseed, surrounded by a vascular halo. There were no signs of constitutional disturbance.

A careful search was made for the primary sore. Just under the edge of the lower jaw, on the left side, I discovered a swollen gland, as large as a walnut, and of stony hardness. None of the other lymphatic glands in the body were appreciably enlarged. Inspection of the gums and inside of the cheek, however, disclosed nothing abnormal. Suspecting that inoculation had occurred in the gum, I questioned the mother closely, and elicited the fact that she had punished the child some six or seven weeks before for sucking his father's tooth-brush. The father was suffering at the time from an "ulcerated mouth." I then got the mother to undo her dress, and found her chest and shoulders pretty abundantly covered with a macular exanthem, undoubtedly secondary, which had been out for about two months, but for which, as it had caused her no inconvenience, she had not sought advice.

The child quickly recovered under small doses of the perchloride of mercury. The rash faded, and the enlarged gland grew softer and shrank. Some years hence he may probably develop symptoms of a kind most puzzling to any observer ignorant of the present interesting episode in his pathological history.

My object in publishing this case is not so much to add one to the numerous instances in which syphilis has been communicated in unusual ways and at unusual periods of life; it is rather to draw attention to the fact that the possibility of accidental inoculation is not, perhaps, always so vividly before our mind as it should be. Anyone who has occasion to see much of constitutional syphilis must be struck with the occasional impossibility of tracing the disease to its source. The difficulty is generally, and for the most part correctly, set down to the not unnatural dislike of patients to admit exposure to the usual sources of infection. But I am convinced that our scepticism may sometimes be pushed too far. I am satisfied that in a small residue of cases the patient is really in the dark as to the cause of his malady, the immediate effects of inoculation not having been troublesome enough to make him seek professional advice, and the seat of primary mischief not being such as to excite his suspicions regarding its nature. It is conceivable, for example, though I have never met with a case, that inoculation may be effected by laryngeal or dental instruments, especially by the latter. It is customary to wash such instruments in water after using them, though I have known even this precaution neglected. But I am inclined to think, from some inquiries I have made, that they are not, as a rule, soaked in any disinfectant liquid—the only process capable of affording an absolute immunity from the risk of specific contamination. It must be remembered that a patient who has a carious tooth stopped or extracted is not likely to go out of his way to state that he is suffering, or has suffered, from syphilis, and there may be no local signs of the disease to rouse the suspicions of the dental surgeon. There ought to be no difficulty in making it a universal and invariable practice to steep all instruments that are brought in contact with mucous surfaces in a solution of carbolic acid (1 to 20), or in one of potassic permanganate, after every time that they are used.

Weymouth-street, W.

MULTILOCULAR OVARIAN DISEASE; SEMI-SOLID CONTENTS; OVARIOTOMY.

BY JOSEPH LITTLEWOOD, M.R.C.S., &c.,
SURGEON TO THE NOTTINGHAM GENERAL HOSPITAL.

K. N——, aged twenty-six, a tolerably healthy-looking young lady, was seen by me last summer. She had been suffering from excessive menorrhagia for a considerable time, and some gradual enlargement of the abdomen had been observed. On examining the abdomen the sense of fluctuation was somewhat obscure. I was satisfied, however, that the case was polycystic disease of the left ovary. Before deciding to operate I wished to have Mr. Bryant's opinion; accordingly he saw her on the evening of October 19th, at Nottingham, and concurred with me in the propriety of ovariotomy being performed, which I did the following morning, Mr. Bryant being present, as well as my friend and colleague at the hospital, Mr. White, and Mr. Anderson.

On Oct. 20th an incision was made from just below the umbilicus to within an inch and a half of the symphysis pubis, the carbolic spray being used, but, with the exception of using boracic lint and a piece of gauze to the abdomen, no further antiseptic precautions were observed. On exposing the tumour there were found very slight adhesions on the left side near the front, which were quite recent. The contents of the tumour were too thick to pass through the cannula, part resembling glue, part porridge, the remaining cysts containing what looked like decomposed blood, but of the same consistence as the others. The cyst wall on the right side was getting very thin and friable, so that no hold could be got with the vulsellum; consequently, in breaking down and removing the contents, it was impossible to avoid some escape into the cavity of the peritoneum. The pedicle was of fair length. A clamp was applied, and, after carefully sponging out the abdomen, six deep sutures were used, a piece of gauze and boracic lint fixed by strapping were applied, a morphia suppository was introduced into the vagina, and repeated per rectum two or three times. Tumour weighed 15 lb. In the afternoon she complained of great pain in the abdomen, which diminished in the evening. At 9.30 P.M. her pulse was 96, temperature 100·8°.

Oct. 21st.—Had a fair night. She feels sick, and has frequent attacks of hiccough, as well as an uncomfortable feeling all over abdomen. Gave her morphia hypodermically. 9.30 A.M.: Pulse 80; temperature 99·8°. 9.30 P.M.: Pulse 78; temperature 99·2°.

22nd.—Complains of great pain in left iliac region, which came on after a severe attack of hiccough, which was relieved by the morphia injection. 9.30 A.M.: Pulse 100; temperature 100·5°. 9.30 P.M.: Pulse 110; temperature 102°.

23rd.—Feels sick, and has much flatulence. Bismuth and soda mixture ordered, which gave her no relief. 9.30 A.M.: Pulse 108; temperature 99·8°. 9.30 P.M.: Pulse 110; temperature 100·1°.

24th.—Called up at 6 A.M. Found my patient had had a very disturbed night, constantly vomiting, chiefly a dark-coloured fluid resembling bile. All food to be discontinued by the mouth; to suck ice, and to have beef-tea enemata. In the forenoon she passed some muco-purulent fluid tinged with blood from her bladder, attended with violent pain in lower part of abdomen. Hypodermic injection of morphia (quarter of a grain), with atropine ($\frac{1}{100}$), was given and repeated, which relieved her pain and for a time stayed the sickness. During my evening visit she vomited nearly a pint

of brownish fluid. 9 A.M.: Pulse 104; temperature 99·2°. 9.30 P.M.: Pulse 104; temperature 98·6°. Ordered three grains of chloride of mercury at bedtime.

25th.—Had a good night. Nausea and sickness passed off. She slept well, taking freely of milk and soda-water. In the early morning the bowels were twice moved effectually, a large quantity of flatus escaping. 9.30 A.M.: Pulse 90; temperature 99·5°. 9.30 P.M.: Pulse 94; temperature 98·5°.

26th.—Sutures removed, as they were producing slight irritation in their course; wound healed down to pedicle. From this time she made a fair recovery, the only source of anxiety being a slight elevation of temperature about commencement of third week, attended with aching pain, not increased on pressure, in left iliac fossa. This pain was considerable when and after the bowels were moved, which had to be brought about by enemata, &c. The clamp caused much dragging, and on the eighteenth day, as this did not seem to be separating, I tied a bit of elastic band under it, and the separation occurred that evening, much to the relief of the patient. She was up on the twenty-second day, but as the slight elevation of temperature and sigmoid tenderness still continued, I deemed it prudent to keep her in bed until those symptoms entirely passed away.

Nottingham.

A Mirror OF HOSPITAL PRACTICE, BRITISH AND FOREIGN.

Nulla autem est alia pro certo noscendi via, nisi quamplurimas et morborum et dissectionum historias, tum aliorum, tum proprias collectas habere, et inter se comparare.—MORGAGNI *De Sed. et Caus. Morb.*, lib. iv. Proœmium.

ST. MARY'S HOSPITAL.

EXTENSIVE VESICO-VAGINAL FISTULA; PLASTIC OPERATION; DEATH.

(Under the care of Mr. EDMUND OWEN.)

FOR the following notes we are indebted to Mr. H. E. Juler, registrar.

In May, 1877, a small unmarried primipara, twenty-three years of age, was delivered of a still-born child, in a village in a western county. She was four days in labour, and unable during this time to void her urine. No instruments of any kind were used, and when parturition was over it was discovered that the patient had lost all power of holding her water. She did not leave her bed until the sixteenth week after her confinement.

In May, 1878, when admitted to the Manvers ward of St. Mary's Hospital, she was in fair health, though pale and low-spirited. Examination showed that the whole of the wall between the bladder and vagina had perished. The aperture between these cavities was not a rent, but was evidently the result of a sloughing of the tissue which had been so long jammed between the distended bladder and the fœtal head lodged in the pelvic strait. The gap extended from the neck of the uterus to the urethra; the posterior extremity of the latter passage being occluded by a firm cicatrix. The roof of the vagina had disappeared throughout its entire width, and the anterior wall of the bladder bulged into the vagina.

As it was impossible, on account of the great loss of tissue, to approximate the edges of the opening, Mr. Owen decided to close the vulva up to the urethra, and thus convert the bladder and vagina into one large cavity. The first step of the operation consisted in re-establishing the urethra; and this having been done, a small drainage-tube was left in it to prevent it becoming again blocked up by granulations.

Three weeks afterwards the sides of the vulva were pared and brought together by wire sutures as far as the urethra, so that the bladder, uterus, and vagina had no communication with the exterior of the body, except by the urethra, in which a soft catheter was left.

After this operation the girl improved greatly in appearance and spirits; for she found that as she lay in bed the urine no longer dribbled away, and that though when she sat upright or stood up some of the water ran off, still after the tube had been removed she had considerable control over the vesico-vaginal reservoir.

On a careful inspection of the parts being made a month afterwards, it was found that the vulva was not quite closed up to the urethra; so this last part of the operation was accomplished on June 27th, and was followed by further improvement. During the month of August, the patient spent much of her time in the garden, and gained flesh and strength; but about the middle of September she began to lose ground. The urine became thick, purulent, and offensive, and although the cavity was washed out twice a day, it could not be kept free of irritation. Moreover, there was great pain across the loins, especially over the region of the right kidney; for this no treatment which was tried proved of much avail, and after a fortnight of severe suffering the patient died.

Notes of Autopsy, by Mr. A. J. PEPPER, pathologist.—Vulvar aperture nearly closed by cicatrix from operation; body of uterus normal, cervix deeply congested. Bladder quite empty; mucous membrane congested in patches, but otherwise healthy. Aperture leading from vagina to bladder. Right ureter and pelvis of kidney greatly dilated, and containing sanguineous grumous matter. Ureter firmly imbedded in old cicatricial tissue, which completely obliterated it where it should open into bladder. Renal capsule adherent; cortex riddled with abscesses; pyramids atrophied from pressure. Between the abscesses were pale softened foci, the result of acute interstitial nephritis. Weight 8 oz. Left kidney and ureter presented a similar condition, though in a less advanced stage, the opening into the ureter being not quite obliterated; weight 3½ oz. The pelvic viscera were matted together by old bands of firm fibrous tissue. There was no sign of recent pelvic cellulitis or peritonitis.

Remarks by Mr. OWEN.—Throwing the three cavities into one, so that the urine and the menstrual fluid should escape by the urethra, is probably the only operation which suggests itself in dealing with a vesico-vaginal fistula so extensive as that which is reported above, and practically it was a success. The fatal issue cannot be attributed to the surgical interference, but was the direct result of an attack of acute inflammation of kidneys which had already been rendered incompetent by previous severe disease. The pelvic cellulitis which followed on the prolonged labour had caused such a permanent and thorough blocking of the lower end of the ureters, that the kidneys had been at times filled with, and irritated by, decomposing urine, so that a condition was induced which is so often observed in the post-mortem examination of men who have died of stricture—enlarged prostate, or stone, and which is known by the objectionable name of "surgical" kidney. It is unfortunate that the urine had not been examined previous to operation, though in all probability the examination would have thrown no light upon the pathological condition; certainly, at the time the patient was undergoing the operations the urine was clear and pale.

SEAMEN'S HOSPITAL, GREENWICH.

CASES OF INJURY TO THE SKULL, WITH CEREBRAL SYMPTOMS.

(Under the care of Mr. DAVIES-COLLEY.)

THE following concludes the series of cases of injury to the skull, the report of which was commenced in our last number, p. 733.

CASE 4. *Fracture of vertex of skull; laceration of brain-substance and intracranial hæmorrhage, the result of contre-coup; death.*—T. L——, aged thirty-six, a gasfitter, was admitted into the hospital early in the morning of Dec. 18th last, unconscious, in charge of two policemen. The history showed that, after being detected in a private house into which he had broken, he had thrown himself from the window of an upper storey, and fallen upon his head. The height of the window was said to be from 12 to 14 feet. The pupils were contracted to the size of pins' heads, inactive, but equal; breathing quiet (28 to the minute), occasionally stertorous; face rather, but not very, pale. He could not be roused to speak. The right ear and its surroundings were covered with blood, bruised, and torn. There was no escape of cerebro-spinal fluid. There was a scalp wound on the right side of the head posteriorly. He was very sick, and had been before admission, the vomited matter smelling strongly of beer. Pulse full, quiet, 84; no loss of

power. Had passed water. In the evening he was lying quiet; pulse good.

On the 19th the nurse announced that the patient had become suddenly worse. The face, it was said, at first turned quite livid, but when the house-surgeon arrived it had recovered its colour; the breathing was stertorous; the man could not swallow; he had passed urine in bed; pupils very contracted, but still equal. Ordered milk diet. To have five grains of calomel at once. Pulse 92, wanting in tone, irregular, and less full. Temperature 102°. In the afternoon he had somewhat improved. He could sit up for a minute or so in bed, but every attempt to make him speak failed. Evening temperature 101·4°. Condition unaltered.

On the 20th the pupils were slightly larger, but unequal, the right being the larger, and both were inactive. The man was very drowsy, and refused nourishment. Pulse 100, small and very feeble. Temperature: morning, 100°; evening, 99°. No obvious alteration.

On the morning of the 21st he seemed somewhat better. He had taken some nourishment; the pupils were larger, and again equal, and active on exposure; the bowels were not open; he passed urine involuntarily; has not spoken, and was still unconscious, but could turn himself in bed; pulse 86. Temperature: morning, 99·2°; evening, 99·2°.

On the 22nd the temperature in the morning rose to 100·4°; but fell in the evening again to 100°. He died quietly early on the morning of the 23rd.

Necropsy, five days after death.—Body well nourished, muscular, traces of commencing decomposition. The skull only was examined. The scalp wound on outer and back part of head on the right side was found to have united. The scalp being removed, a patch of extravasated blood was noticed beneath the pericranium at the seat of injury, and at the same spot the outer table was slightly depressed. There was also a linear fracture starting from the spot above mentioned, extending in a forward direction and slightly inwards. This fracture communicated posteriorly with the parieto-occipital suture (right side), which for a part of its extent had been "started," the separation between the bones being more marked than on the opposite side, and it was possible to move them. On removing the calvaria, the inner table was found intact at the seat of injury. No hæmorrhage had occurred between the dura mater and the skull, but there was great distension of vessels of the pia mater. The vertex of the left hemisphere was covered with a large quantity of coagulated blood. The upper convolutions of the left temporo-sphenoidal lobe were soft and diffluent, and the middle fossa of the left side, in which the hæmorrhage had been most abundant, was chiefly occupied by coagulated blood and broken-down brain-tissue—so much so that there was very little of the left temporo-sphenoidal lobe to be seen. A portion also of the left lower frontal convolutions had been ploughed up by the hæmorrhage. No fracture of the base of skull in middle fossa on either side was found, and an examination of the right auditory apparatus revealed a laceration of the membrana tympani, which would account for the hæmorrhage from the ear during life. No blood was found in the tympanum, no hæmorrhage had occurred into the substance of the brain, nor was there any lymph to be seen in the subarachnoid space. With the exception of the increased vascularity of vessels of the pia mater, no further pathological change, as far as could be discovered after a careful examination, had taken place.

COVENTRY AND WARWICKSHIRE HOSPITAL.

CANCER OF KIDNEY; SYMPTOMS RESEMBLING THOSE OF VESICAL CALCULUS.

(Under the care of Mr. MILNER MOORE.)

G. W——, aged twenty-eight, sought advice as an out-patient in September, 1877, complaining that for the last four months he had had pains in the left loin, urine tinged with blood, and at times pain and difficulty in micturition. At first there was an interval of several weeks between the attacks, but more recently he had been seldom free from pain, and had experienced much discomfort over the region of the bladder. On three separate occasions his bladder was carefully sounded, but with negative results.

In November he was first seen by Mr. Moore, when he was emaciated and miserable-looking. He had constant pain in the left loin, but nothing could be felt on deep pressure, which, however, gave him pain. The urine contained blood-corpuscles in considerable quantities, but no other organism.

As he became so much worse he was made an in-patient in January, 1878, and a few days after his admission a distinct tumour could be detected an inch and a half to the left of the umbilicus, and on a level with it. The tumour felt quite smooth, and appeared to be pointed, and, on pressure upon the left lumbar region, could be made to move. There was no swelling of the abdomen generally, and no greater prominence existed on one side than the other. At this time the urine was pale and clear, free from albumen, sp. gr. 1010, and nothing abnormal could be detected when examined microscopically. The patient's temperature never exceeded 100° F.

The tumour increased in size perceptibly even during the short time he lived after admission. Occasional vomiting and diarrhœa came on. He rapidly sank, and died on February 10th.

The post-mortem examination was made on the following day. The body was much emaciated. Skin of abdomen greenish; scarcely any fat in the tissues. The transverse colon was distended with gas, but there could be seen projecting between it and the folds of small intestine on the left side the cone-shaped apex of a hard, smooth, and immovable tumour. The intestines were removed, and the tumour, which proved to be a large distended kidney, dissected away. It then presented the form of a cone with flattened lateral surfaces, with a large depression at its base. Measurements: Across the base, seven inches; from base to apex, five inches; thickness, two inches and a half. When freed from extraneous matter it weighed 32½ oz. The cut surfaces showed a small portion of much-changed kidney-structure, at the upper angle occupying about one-eighth of the whole surface. The remainder was made up of hard masses of colloid-like structure, soft encephaloid-like growths, and cysts varying in size from a pea to a walnut. Sections placed under the microscope were seen to consist of nucleated cells of varying shapes and sizes, intertwined with fibrous stroma. The pelvis of the kidney was much dilated, and the ureter patent throughout. The abdominal glands in the neighbourhood of the tumour were much enlarged. The right kidney was large, and presented signs of granular degeneration.

Remarks.—A somewhat remarkable feature in the early history of this case was the presence of hæmaturia, so profuse at times as to cause difficult micturition and symptoms of calculus, probably from coagulation of blood, while the bladder was empty. Then there came a time when no more blood was discharged—namely, for two months before his death; and it appears somewhat difficult to account for the absence of hæmaturia while the disease of the kidney was so rapidly advancing.

DEVON AND EXETER HOSPITAL.

POPLITEAL ANEURISM; CURE BY FLEXION FOLLOWED BY THREE HOURS' DIGITAL COMPRESSION.

(Reported by H. GORDON CUMMING, F.R.C.S., Resident Surgeon.)

THOMAS C——, aged forty-eight, by trade a carpenter, was admitted on Jan. 15th, 1879. About four months before he sought advice for a severe pain in the leg, which he thought was rheumatic. An aneurism was found in the popliteal space. He was taken into a cottage hospital, and intermittent pressure was made on the superficial femoral artery with a tourniquet for about three hours, but it could not be endured.

When admitted into the Devon and Exeter Hospital he was to all appearance in good health, and expressed himself as being so. No appreciable change in the condition of the superficial arteries could be found, but with a stethoscope a loud double aortic bruit was audible over the aortic region and along the sternum. The left leg was œdematous about and below the knee, and the veins were slightly varicose. There was an elongated aneurism of the popliteal artery, with a transverse diameter of about an inch, as near as one could judge, and having a very forcible pulsation.

The leg was flexed upon the thigh, and retained in this position with a bandage. While so fixed, the pulsation in

the tumour was scarcely to be felt; extreme flexion completely arrested it.

In a few days some enlarged arterial branches were very evident in the thigh, about the knee, and in the popliteal space; one of these passing directly over the sac, and another along the outer hamstring muscles. The pulsation in the sac was undoubtedly lessened by the flexion, but as this had been continued for eight days, and was at times extremely irksome, digital compression was commenced.

After this had been most carefully employed for about two hours, a marked hardness of the tumour was observed, and in rather less than another hour all pulsation had ceased. The patient was discharged well in a few days.

Remarks.—Apart from the direct effect of the flexion, as indicated by the almost complete arrest of pulsation in the sac whilst the limb was in this position, there seemed good evidence of control exercised in the flow through the artery at the seat of disease from the establishment of the well-marked collateral branches above mentioned, and one cannot but remark the rapid effect following on the compression as having been materially assisted by changes which had already taken place in the aneurism as the result of the previous flexion.

Medical Societies.

ROYAL MEDICAL & CHIRURGICAL SOCIETY.

Deligation for Aortic Aneurism of the Right Carotid and Subclavian Arteries, with a new species of Ligature.

THE ordinary meeting of this Society was held on the 27th inst., Mr. J. E. Erichsen, F.R.S., President, in the chair. A paper by Mr. Barwell, recounting a case of aortic aneurism, in which deligation of the right carotid and subclavian arteries was practised, the ligature used being made from the middle coat of the ox's aorta, occupied the evening. The author endeavoured to lay down rules for guidance in selecting for ligature the right vessels. At the close of the evening it was announced from the chair that owing to accumulation of papers a special ordinary meeting would be held on Tuesday next, June 3rd; the first paper on the list being one by Dr. Gowers on the movements of the eyelids.

The following is an abstract of the paper "On Deligation for Aortic Aneurism of the Right Carotid and Subclavian Arteries, with a new species of Ligature," by Mr. RICHARD BARWELL. The author reminded the Society that he has already recorded four cases of double ligature of those vessels, three of which were successful, and pointed out that the same operation was in the present case undertaken not for innominate but for aortic aneurism. As this practice and the ligature used are new to surgery, somewhat lengthy remarks would be necessary, hence the case must be briefly recorded. John S——, aged thirty-six, grey and old for his years, was treated by Dr. Green for an aneurism of the aorta which pressed upon the right bronchus, and by the middle of February, six weeks after admission into Charing-cross Hospital, that tube was very nearly closed, and the right lung occluded from the air. On the 15th of February Mr. Barwell tied the right carotid and subclavian arteries with immediate sense of benefit to the patient, who continued to improve, air entering the lung freely until the end of March, when some private news produced great excitement, and shortly afterwards symptoms of dilated aorta about the origin of the left subclavian appeared. These again diminished, so that in the first week of May the man was in a far better state—air entering the right lung—although some disease of that organ had been produced by the previous pressure. *Remarks.*—The three large branches of the transverse aorta are not given off at right angles to the trunk, but so obliquely that the distal margin of the orifice of each lies lower than the proximal; from this distal margin run downward and to the right certain ridges which, acting on the blood-stream, divert the current at that part into each orifice. These ridges divide the upper aspect and a portion of the antero-posterior wall into districts, one for each vessel. A fibrous concretion detached from an aortic valve finds its way, as a rule, into the left carotid—a fact which has given rise to the idea that this vessel lies more in a straight line with the aorta than the right. Mr. Barwell showed the contrary to be the fact—that a probe passed down the left vessel impinges on the aorta near its origin, and that one passed down the right artery enters the heart. He concludes that we can only account for concretions going to the left carotid by believing that on the right of the ascending aorta (the exact part was shown in diagram) the blood current is more tranquil than on the left of that vessel; the two currents may be supposed separated by a line drawn from the left carotid orifice to the outer aspect of the origin of the aorta. Hence it may be concluded that for aortic aneurisms amenable to operative treatment those that can be diagnosed as arising to the right of this line must be treated by tying the right vessels, those on the left by deligation of the left carotid. The ligature used has been the subject of much care and experiment. Catgut has been shown to be unreliable for tying vessels in continuity; it does not appear that this depends on the method or period of soaking in carbolised oil. The author attributes its defects to the method of manufacturing the catgut itself. Putrefaction in water enters largely into this process; different parts will have suffered in various degrees from putrefaction. But more objectionable even than this is the shape of the ligature, for it is difficult, perhaps impossible, to avoid dividing the inner coats of vessels tied with a round cord. Now, it is this division of vascular coats that exposes patients to the dangers of secondary hæmorrhage, which has been the cause of death in almost every case hitherto recorded of tying the innominate or first part of the subclavian. An organisable ligature, which, being flat, does not divide the arterial coats, ought to secure surgery against this danger. After many experiments the author hit on the idea of using the middle coat of oxen's aorta, which, being quite fresh, is to be prepared by separating it from the outer coat and by cutting it spirally, thus making long flat tape-like ligatures, which are dried under suspension by a weight to remove superabundant elasticity. Just before use they are moistened to restore entire flexibility. Before attempting operative surgery with this material it was tested experimentally in various ways, and in the case recorded its action left nothing to be desired. If the anatomical and physiological views propounded in the first part of this paper are correct, a precision, as yet wanting, will have been given to operative procedures in cases of aneurism, while by the new ligature a degree of safety hitherto unattained will have been imparted to the operations themselves. — At the conclusion of the paper Mr. Barwell exhibited specimens of the ligatures described therein.

Mr. NAPIER, speaking of catgut ligatures, pointed out the importance of steeping them in boiling water for an hour or so previous to their use.—The PRESIDENT said Mr. Barwell's case presented many points of importance in surgery and in medicine. It was the first case in which the treatment had been adopted knowingly for aortic aneurism, for in the first case in which the carotid and subclavian were tied an aneurism of the aorta was thought to be innominate, and the ligature was applied under that mistake. But Mr. Barwell's case raised a new principle in the treatment of aneurism, for it was a different thing to tie the carotid and subclavian for innominate than for aortic aneurism. In the former some effect might be produced, but it was difficult to see how, in the latter case (when the whole length of the innominate lies between the seat of ligature and the aorta), the stream in the aorta could be affected. If any effect were at all produced it would be to augment the volume and force of the blood sweeping through the aorta. As to the other operation for aortic aneurism—viz., ligature of the left carotid—there have been cases fairly successful; but he had thought that sometimes the occlusion of the carotid was rather the effect of commencing consolidation of the clot in the aneurism than the cause of this. Further, he urged extreme caution on the part of surgeons in resorting to ligature for aortic aneurism. Cases had failed, and in them disease of the heart or extensive disease of the aorta was present; so that, looking to the extreme difficulty of diagnosis, the fact that by medical treatment life may be prolonged for many years, and the risks entailed by operation, he would hesitate much before assenting to the proposition that ligature of the large vessels at the root of the neck was an advance in the treatment of

aortic aneurism.—Dr. GREEN said the diagnosis of aortic aneurism in the case related by Mr. Barwell was beyond doubt; but he could not pretend to say how far it involved the innominate. The man was treated by rest, restricted diet, and iodide of potassium in large doses; but in spite of all the pressure symptoms increased. These symptoms were chiefly those of pressure on the right bronchus, so that the air entered the right lung very imperfectly. Dr. Green then passed the case over to Mr. Barwell, and he was astonished to see the marked improvement that took place in a few days after the operation—the pain and dyspnœa ceased, and the lung expanded more freely. Still it was probable that the aneurism would again increase. He thought that during the last week or two pulsation had increased.—Mr. HOLMES said that all must concede the difficulties there are in the diagnosis of these cases, and the inadvisability of resorting to such radical measures as ligature of the subclavian and carotid until a fair attempt had been made to treat the case medically. But there was no doubt that surgical interference had saved patients from apparently imminent death. In the case of the young girl on whom he had operated there was no question as to her desperate condition. She had been treated for a long time medically. It is now four years since the operation, and she is still in moderately good health. Still, he confessed to not being clear as to the precise part of the aorta involved, and did not think Mr. Barwell had clearly shown how the distinction could be made during life between an aneurism springing from the right and one from the left side of the aorta. In the case described the evidence was certainly strong in favour of its springing from the right half of the aorta, whilst the want of any difference between the radial pulses excluded the idea of its being an innominate aneurism. His own rule was to delay operative interference until, by its extension up the neck, the aneurism threatened life by pressure on the air-passages. He still adhered to the opinion, opposed to that of Wardrop, that the effect of tying the third part of the subclavian is to increase the circulation through the first part and to cause the enlargement of the collaterals. He asked what proof Mr. Barwell had in favour of the view that obliteration of the first part of the subclavian followed on ligature of the third part. But he believed that the great benefit results from coagulum extending along the carotid into the sac of the aneurism. Speaking of the new form of ligature, Mr. Holmes hoped that it would be found to answer its purpose, which was the same as that had in view by John Hunter when he tied the femoral artery by flat tapes in order not to divide the coats. In order to be efficient, the ligature should undergo no change for a long time—a year or so. If Mr. Barwell could promise this, then he (Mr. Holmes) for one would never attempt to divide the internal and middle coats of the vessel. It was the insecurity of catgut, its rapid absorption, that made it absolutely necessary to divide the coats in using the ligature. He confessed there was not the slightest evidence in favour of the organisation of catgut ligatures. If Mr. Barwell's ligatures would organise, they would be very valuable indeed.—Mr. SPENCER WATSON had lately tied the external iliac for femoral aneurism with catgut, without dividing the internal coats, and with most satisfactory result. At the same time, he admitted that catgut was unreliable for ligature. He supposed Mr. Barwell would not use his flat ligatures for any small arteries. He was pleased to find that the knot made by the ligature was smooth and flat.—Mr. MYERS, in reference to a statement in the paper, said that he was under the impression that the force of the blood stream was thrown to the right, and was much greater than in the left of the aorta.—Mr. BARWELL, in reply, said that the "new principle" of his operation was really involved in the considerations advanced by Dr. Cockle, in favour of ligature of the left carotid for aortic aneurism. The question was not yet settled. The cases already on record show that a certain influence for good is produced in the aortic current by deligation of vessels at the root of the neck. Mr. Heath's case, Mr. Holmes's case, and his own former case, where life was prolonged for ten weeks, were instances of this; and although it was true that in Mr. Heath's case the deligation was practised under an error in diagnosis, he (Mr. Barwell) doubted if it would have got well had the left and not the right vessels been tied. Was it possible to distinguish those cases in which deligation should have a curative effect and those in which it should not be curative? And then could we distinguish between those cases in which the right carotid should be tied and those in which the left? In cases such as the one read that night the position of the aneurism was not doubtful, and by a careful study of previous symptoms, sphygmography, &c., a clear diagnosis may often be carried out. He agreed with Mr. Holmes, that encroachment of the aneurism on the respiratory organs should be taken as an indication for operation. He would not tie rashly nor inconsiderately, and would, if possible, try to get a clear idea of the position of the aneurism; nor would he operate until medical measures had been exhausted. As to the ligature, he hoped it would prove efficient. As long as it remained around the wound, so as to occlude it until the coagulum had become firmly adherent to the walls of the vessel, it would fully serve its purpose. He differed entirely from Mr. Holmes in his criticism upon the effect produced on the first part of the subclavian by ligature of the third part. In one of his previous cases the subclavian became completely obliterated; whilst in his lectures Mr. Holmes gives eleven cases in which the carotid only was tied and the subclavian left, all of whom died from increase of the aneurism, due as he (Mr. Barwell) believed, to the continued flow of blood through the innominate.

The meeting then separated.

PATHOLOGICAL SOCIETY OF LONDON.

Specimens of Equine Skin Disease.—Foot with Nine Toes.—Rupture of Aorta.—Recto-vesical Fistula.—Nature of Iodide of Potassium Eruption.

THE ordinary meeting of this Society was held on the 20th instant; Mr. J. Hutchinson, President, in the chair. The chief business consisted in the reception of the Report of the Committee appointed two years ago to inquire into the nature, causes, and prevention of the infectious diseases known as pyæmia, septicæmia, and purulent infection. The report, which was very voluminous, was read in abstract by Dr. Ralfe. It was illustrated by a large number of microscopical specimens.

The PRESIDENT announced that the Council had drawn up the following regulations to admit of an extension of the work of the Society:—"1. That in order to facilitate the exhibition of specimens, and to save the time of the Society's meetings, it is desirable that arrangements should be made under which preparations, drawings, &c., may be shown without any *oral* communication. 2. That the following be the conditions under which such exhibitions may be made:—(*a*) The specimens or drawings must be ready for inspection in the Society's rooms not later than 8 P.M., and must remain on the table until ten minutes after the close of the meeting. (*b*) A card, provided by the Society, must be placed with the specimen, and on it must be clearly written a short account of the specimen, comprising all the particulars intended for publication. The exhibitor (or his representative) must be present at the meeting, and be willing to furnish additional details if asked for. (*c*) That, at every meeting of the Society, the rooms be open for the inspection of specimens, &c., at 8 o'clock; the chair to be taken as usual at 8.30 P.M. (*d*) That the list of specimens exhibited by card be read to the meeting by the President; and that such specimens be taken for consideration and discussion in the course of the meeting, alternately with other specimens, at the discretion of the President. (*e*) That the Council be requested to act as a committee to supervise the working of the new regulations."

Mr. BUTLIN read the report of the Morbid Growths Committee upon Mr. Lister's specimen of tumour of the scapula. They found it to be of the nature of encephaloid carcinoma, but could not determine whether it grew primarily from the scapula. Mr. Butlin also read the report of the same committee on Dr. Sangster's and Mr. Bellamy's specimen of rodent ulcer of the face and nose, and Mr. Godlee a report from the committee upon Mr. Heath's specimen of tumour infiltrating the scapular muscles. They found it to be a fibro-sarcoma.

Dr. RALFE, as Secretary to the Committee appointed to epo rt upon the Nature, Causes, and Prevention of the In-

fectious Diseases known as Pyæmia, Septicæmia, and Purulent Infection, then read an abstract of the report, a summary of which we gave last week.—The PRESIDENT said that the report just read in abstract was the work of a committee the formation of which was due to the initiative of their late much lamented President, Dr. Murchison. It was through his exertions that a Government grant had been obtained for the purpose of the inquiry, and in January, 1877, an acting committee was nominated, consisting of Mr. Marcus Beck, Dr. Greenfield, Dr. Ralfe, and Mr. McCarthy. It was not in accordance with the custom of the Society to discuss any report of a committee. The report would be printed in the Transactions, and he felt sure it would prove a most valuable addition to our knowledge of these diseases. He begged to propose with great pleasure that the best thanks of the Society be awarded to those gentlemen for the energy with which for two years they had prosecuted their labours, and for the exhaustive report they had furnished. He would add that the Committee exhibited microscopical preparations illustrative of the report.

Dr. THIN showed microscopical preparations of Disease of the Skin in the Horse. The first was a specimen of a sebaceous tumour, which presented some differences from sebaceous growths in man. The tumours varied in size from a pin's head to a bean, and were composed largely of capsules formed of flattened epithelial cells. The second specimen was a form of erythema circumscriptum, which occurred in the skin in connexion with suppuration of the cellular tissue following suppuration of the submaxillary glands. The eruption consisted in small discoid elevations, with definite raised margins, but microscopically the borders of these swellings were not defined by any leucocytic infiltration. It would seem as if they were composed solely of serous effusion from the bloodvessels, and he suggested that the cellulitis present in the case might have led to the absorption of material, which so modified the walls of the vessels as not to permit of emigration of leucocytes. The condition might throw some light on the nature of ordinary erythema in man. The third specimen was from a case of so-called "eczema" of the horse. It showed microscopically changes in the hair-follicles, whereby the hairs had fallen out and the sebaceous glands had broken up. Minute abscesses occurred in connexion with these follicular changes. It was not strictly an eczema, for there was no cell infiltration; nor could it be styled "acne," for that is really a perifollicular inflammation external to the hair-shaft. In reply to the President, he said that he had only examined this from a single horse.—The PRESIDENT had seen a spreading eczema in a horse starting from a sore on the back, and he had compared it to porriginous eczema of man.

Dr. POWELL (hon. sec.) exhibited for Mr. Mason a specimen of a Foot with Nine Toes, from a lad fourteen years of age, associated with congenital deformity of the leg. The foot had been dissected, and exhibited in an interesting way the distribution of the extensor and flexor tendons to the nine toes.

Dr. NORMAN MOORE showed a specimen of Rupture of the Aorta. The patient, a male adult, was admitted into St. Bartholomew's Hospital with signs of aortic and possibly mitral valvular disease. Death occurring suddenly, the pericardium was found to be distended with blood to the amount of two pints. The heart was moderately hypertrophied; the aortic valves incompetent, and greatly deformed by old disease. In the aorta, one inch above the valves, was a transverse rent, and a short distance above this a second and smaller rupture. The rupture had dissected down between the coats into the pericardium. Dr. Moore thought it possible that the rupture in the aortic wall had taken place a short time before death, which was brought about by the final rupture into the pericardium. The aortic wall was very thin at the seat of rupture. The cerebral arteries were normal. No similar case had been met with in St. Bartholomew's Hospital during the time that the post-mortem records had been kept—viz., from October, 1867.

Dr. MORISON exhibited a specimen of Recto-vesical Fistula. The patient was fifty years of age, and had suffered from symptoms, commencing with difficulty and pain in micturition, from 1874. After a time flatus and fæces were passed per urethram, followed by the formation of a fæcal abscess in the perineum, death occurring from septicæmia four years after the onset of symptoms. At the post-mortem examination there was found plugging of the left saphena vein and of the left internal iliac branches. There was a stricture in the lower part of the sigmoid colon, and just above this an aperture leading into a sloughing abscess between the bladder and rectum, the sac opening into the bladder. There was fæcal extravasation between the bladder and rectum, and the bladder contained some feculent materials. Dr. Morison thought that the bowel must have been primarily injured by a foreign body—e.g., a fish-bone,—leading to a perirectal abscess subsequently opening into the bladder, and that the stricture of the gut was secondary to the inflammatory changes around it.

Dr. DUCKWORTH and Mr. HARRIS exhibited microscopical preparations from a case of Iodide of Potassium Eruption. The eruption was pustular, and the changes met with were those of a superficial dermatitis, the hair-follicles not being implicated. Dr. Duckworth observed that this was the second case in which the anatomical nature of the rash had been made out. The first case was that recorded by Dr. Thin about a year ago, and the changes observed in the present case confirmed those described by Dr. Thin, both disproving the notion that the eruption was of the nature of acne. It was, on the other hand, a vesicular dermatitis probably induced by the action of the drug on the lining membrane of the vessels.

Several other specimens were on the agenda sheet, but as the ordinary time of the meeting had expired, the President announced that, according to custom, these communications would be taken as read. The Society then adjourned until October.

MIDLAND MEDICAL SOCIETY.

A SPECIAL meeting of this Society was held at Queen's College, Birmingham, on May 21st, 1879—H. M. Morgan, Esq., President, in the chair—"to consider and discuss the proposed legislation for the amendment of the Lunacy Laws, with special reference to the responsibilities of the medical profession, and the proposed conversion of private into public asylums; and, further, to pass such resolutions as the meeting may determine."

Dr. G. F. BODINGTON said:—I shall have to trouble you with a brief historical retrospect in order to illustrate and prove my first proposition, which is this, that private asylums have at no time within the present century been behind public asylums in the matter of the management and treatment of insane patients. I hope to establish that proposition—nay, strange as it may appear, to show that they have been even in advance rather than behindhand. First, let me draw attention to the year 1815. It would be foolish to gloss over the evils of private asylums at that date. There were glaring abuses. But it must be remembered the faults were the faults of the age. It was an age of transition from cruelty to kindness. Humane feelings were about to seize hold of the community, but the change was not complete—in fact, scarcely begun. Amidst the general awakening, the state of the lunatic asylums attracted attention, and an inquiry by a Select Committee of the House of Commons was made—the celebrated inquiry of 1815. Having read the evidence with some care, I come to the conclusion that, bad as some private asylums were, not one of them equalled in cruelty, nay, shocking brutality, the York Asylum and the Bethlehem Hospital of that day. Lest I should be suspected of bias, I refer you to the description of the horrors practised in these two asylums, given by Dr. Conolly.[1] It is to be remembered that the cruelties held up by Conolly to righteous indignation were not in these instances practised by private proprietors, but the authorities, by bodies of governors, lords and gentlemen, men of the highest position in the political and social world. The abuses of York Asylum and Bethlehem Hospital were, at any rate, not due to private greed. They were due partly to ignorance, partly to the cruel and callous spirit of the age. But at the very time when the atrocities which have been so much dwelt upon and quoted were occurring, a reform was being wrought by several philanthropic individuals, amongst whom were three members of our own profession, who were proprietors of private houses for the reception of the insane. They

[1] On the Treatment of the Insane, 1856, pp. 17 and 24 to 28.

were Mr. Fox, of London House, Hackney; Dr. Edward Long Fox, of Brislington House, Bristol; and Mr. William Finch, of Laverstock, near Salisbury. It is shown clearly, in the Minutes of Evidence of 1815,[1] that at a period when the treatment of lunatics was as a rule most horrible, these three men, with a few others, had the wisdom, the humanity, and the courage to set their faces against the current system. They treated the insane with gentleness, with great kindness, and yet they were private asylum proprietors. These facts have been too much forgotten. It is high time they were brought back to the memory of this generation. In 1844 the then newly-appointed Metropolitan Commissioners in Lunacy issued a report on the various public and private asylums throughout England and Wales. Again, it will be found by this report that the licensed houses were not behind the public asylums. There were some bad things recorded of both. The worst case of all, however, was that of the public asylum at Haverfordwest, while in a great many of the private houses the interests and comforts of the insane were admirably cared for. An impartial examination of this report must lead to the conclusion that licensed houses were in 1844 at the very least on a level with public asylums. These statements and comparisons are not made with a view to reflect upon the management of modern public asylums, much less upon their medical superintendents, a body of men of high character and capacity. What is now said is merely said in self-defence. It is said in answer to the numerous and flagrant attempts lately made unjustly to blacken the character of private proprietors and unduly to vaunt public asylums at their expense. In 1877 another Select Committee of the House of Commons sat, and these were the terms of the reference—namely, "To inquire into the operations of the Lunacy Laws so far as regards the security afforded by it against violations of personal liberty." This committee took an enormous amount of evidence. All the cases of alleged illegal detention that could be found were brought forward. Mr. Dillwyn took care that the persons aggrieved should have a full and fair opportunity of explaining their grievances. What was the result? Every case broke down. There were no cases! No tittle of evidence was given to substantiate one single instance of illegal detention. The report of the Select Committee exonerated private asylums. Notwithstanding the complete vindication effected by this evidence and report, the public are not convinced. Newspapers on all sides and of all politics, both metropolitan and provincial, keep up a constant and virulent attack. Cases occurring in public asylums are made the basis of attacks upon private ones. One would think that the proprietors of the licensed houses were a set of the vilest and most mercenary wretches under the sun. When I think of the men against whom these charges are made, I am wonderstruck. Why, Sir, we have names famous in medicine amongst the list of private asylum proprietors. There are at this moment some dozen or more Fellows of the College of Physicians, who are, or have been, proprietors of licensed houses for the insane. One of them has been censor and councillor, and another Gulstonian lecturer. Does the College of Physicians select its fellows from so vile a herd as the newspaper writers would have us believe these men to be? We, who know the whole class, know full well that they are equally honourable and upright with all the other members of the medical profession, or with any body of men that can be named. We know that they do not, and could not be induced to, descend to the mean arts and practices with which they are charged. But what avail all these things? Vindication, it seems, is useless. The public has imbibed an ineradicable prejudice against us, founded on ignorance of the facts, till it has culminated in a determination on all sides to do away with private asylums. Not only has this view permeated the outside world, but it has seized hold of the medical mind. The leading medical journal has declared that the licensed houses must go. ..... No man in his senses would dare to say that private asylums are perfect institutions. But it may be said, without fear of contradiction, that all the evidence adduced hitherto shows that up to the present moment they have maintained the continuity of that happy reform begun by certain private asylum proprietors in the early part of this century, and that there is not a jot or tittle of evidence in any direction to show that they are at all behind public ones in the matters of medical science, humanity, and justice to the insane. That is the substance of my first proposition. The second flows from it as a natural corollary. It is this: that, not having forfeited our position as men of honour and good citizens, the State, in any change it may make in the Lunacy laws, is bound to take care that our interests are not sacrificed; and that if the public insist on driving us from our present positions, they shall let us depart with honour untarnished, and that no stigma shall rest upon us. There can be no doubt that temptation lies in our way. The most extraordinary thing is, that it has been clearly proved that it has not been operative. Whether this is from the very close, jealous, and, as it seems to me, altogether efficient inspection of private asylums, or whether from the character of the men who keep them, it is not for me to say. It may be from both causes. But the temptation, no doubt, exists. There is a motive. Writers for the public press conclude that, the motive existing, it must be acted upon. They are possessed, and they imbue their readers, with an idea—in my opinion an ineradicable idea—that the greed of gain must actuate us, and that the insane, or quasi-insane, must be captured and kept in durance purely from pecuniary considerations. No demonstration of their error will convince them to the contrary. These considerations lead me, Sir, to the conclusion that it would be unwise to resist the proposed abolition or conversion of private asylums. I, for one, will not offer the least personal objection. I will not lift a finger against it. The system of taking care of the insane in private houses is not a system of our creation. It has existed under public sanction from time immemorial. The State from time to time has stepped in to regulate the management. No one complains of that. No one complains of inspection. No one, I hope, will complain of abolition or conversion. All that I demand is this, that we, being men who as a class have done nothing whatever to forfeit our rights as good citizens and true men, shall not be offered up as a sacrifice to popular prejudice upon false pretences. Now comes the question of the method. Supposing the change to be made, on what terms is it to be made? The first thing I have to say is that in the interest of everybody it must be done at once. An immediate settlement of the present uncertainty is imperative. The existing state of things is paralysing. It is injurious alike to the sane and the insane. Mr. Dillwyn has a Bill before the House of Commons for the amendment of the Lunacy Law. This Bill, so far as it concerns the conversion of private asylums is highly objectionable, inasmuch as it is a merely enabling Bill. It is permissive on one side, though obligatory on the other. It would unsettle everything, and settle nothing. Would the justices of counties buy up asylums unless compelled? They might possibly in a few instances. The Bill would operate most unequally. Some counties have many private asylums, some very few, others none. Suppose the justices of one county were to buy up the private asylums, and with all the resources at their command and all their prestige were to compete with the private asylums in adjoining counties in which the justices refused to buy. Or, again, suppose the justices of a county containing a number of private asylums were to buy one—say the one most eligible by situation and other circumstances—and were in similar manner to enter into competition with the others. Would that be just to the proprietors of the asylums not bought? The permissive character of this Bill is a radical and fatal defect, and unless when brought forward there is some assurance that it shall be made compulsory, it ought not, in my view, to meet with the support of private asylum proprietors. We ought to acquiesce without a murmur in the transfer of our establishments to the State on fair terms, but there is no reason whatever why we should consent to have our means of livelihood frittered away by such harassing processes as the Bill of Mr. Dillwyn, in its present form, would introduce. There are other points to consider, but I must forbear and conclude. Now, to recapitulate the substance of this address, I say that private asylums have at no time been behind public asylums in regard to the treatment and management of the insane. They are proved in some instances, in the beginning of this century, to have been far ahead of them. The continuity of the reform begun in certain private asylums has been maintained, and the reform itself has extended to them all. The evidence given before the Select Committee of 1877 has shown that the charges of illegal detention are false. No case of general mal-administration or mismanagement having been made out, no cause exists,

[1] See Minutes of Evidence, 1815; Mr. E. Wakefield's evidence on the state of private houses, &c.

except popular distrust, for the abolition or conversion of private asylums. Hence proprietors have an equal claim with all other good citizens to the protection of their interests by the State. Notwithstanding all this, proprietors of licensed houses ought, in obedience to the popular demand, cordially to acquiesce in the transfer of their establishments to the State, reserving only a just consideration of their interests and the claim that no stigma shall afterwards rest upon their name.

Reviews and Notices of Books.

The Pathology of Pulmonary Consumption. Three Lectures by T. H. GREEN, M.D., F.R.C.P. London: Renshaw. 1878.

WE owe Dr. Green some apology for not having given an earlier notice of this excellent little book, which has been published now for some months. Pulmonary consumption and its relation to tuberculosis has been for years past one of the chief battle-grounds of pathologists, and those who have vainly looked for some tangible result from so much discussion have had to content themselves with noise and smoke and the often doubtful advantage now of this side and now of that. Many pathologists to whom we habitually look for instruction have on this question behaved like veritable weather-cocks, and their opinions have shown a most ominous want of stability, being blown hither and thither by every blast of doctrine, until the mere outsider and looker-on came reluctantly to the conclusion that *ex cathedrâ* utterances were, after all, not unfrequently the offspring of muddled brains.

Dr. Green has evidently made himself most thoroughly acquainted with the work and views of all the chief pathologists, English, German, and French; and, what is more important, he has studied and worked on his own account. He has thus succeeded in producing something like order out of chaos, and has given us a little book which will enable students (*in statu pupillari* and otherwise) to get something like a solid grasp of a most difficult and important subject.

The first lecture is devoted to "Acute Tuberculosis," and that which will be of greatest interest to the reader is the account which Dr. Green gives of "giant cells" and the importance he attaches to them. It is by no means uncommon to meet with cases of tuberculosis in which the pulmonary nodules consist wholly of intra-alveolar accumulations and alveolar infiltrations, and in which the reticulum and giant cell are entirely absent. Upon this point Dr. Green insists. At a later stage the giant cell is often met with, and is found more generally within the alveolar cavity; and Dr. Green is disposed to agree with Dr. Klein as to their probable development from the fusion of alveolar epithelium or from the excessive development of a single epithelial cell. The reticulum is a later development, arising from the budding of processes from the giant cells and the anastomosis of these processes with each other. The alveolar wall becomes, at the same time, the seat of a lymphoid growth which grows into a fibro-nucleated structure and "the fully developed tuberculous nodule that consists of several giant-cell systems, each of which is surrounded by a fibro-nucleated tissue." The relationship of tubercle to scrofula is most lucidly set forth. "There is in both the same tendency to cellular infiltration, the same development of large cells, the same vascular obliteration and retrograde change."

The second lecture deals with the Histology of Phthisis. It is pointed out that the histological changes are mainly four in number, and that each one of them is familiar to us in conditions other than pulmonary consumption. The first histological change consists of the presence of leucocytes and fibrinous exudation within the pulmonary alveoli—a condition with which we are most familiar in acute or croupous pneumonia. The second histological change common in phthisis is the stuffing of the alveolar cavity with catarrhal products, the result mainly of multiplication of the alveolar epithelium. This is the condition which is so common in the broncho-pneumonia or catarrhal pneumonia of children. The third histological change is the infiltration of the alveolar wall with a cellular formation, which is absolutely without vessels and whose tendencies are entirely retrogressive. This is the change which is most characteristic of phthisis. It is invariably found in acute tuberculosis of the lung, and something very similar is familiar to us in various scrofulous infiltrations. The fourth histological change consists of an overgrowth of the connective tissue between the alveoli. This is the condition which we meet with in "cirrhosis" of the lung. This overgrowth tends to become vascular and to develop into fibrous tissue. These four histological changes are associated in different cases in varying proportions, and it is the dominance of one or other variety of change that enables us to separate cases of phthisis into groups which are clinically and pathologically distinct. All these changes, Dr. Green points out, are inflammatory in their nature, and the preponderance of one or another variety of change depends, he thinks, upon the intensity and duration of the inflammatory process. The term "intensity" implies two factors—viz., severity of injury and susceptibility of tissue injured. In those forms of phthisis in which the process is of maximum intensity, the consolidation of the lung being the most rapidly reduced, exudation and emigration of leucocytes may occupy a prominent place, although such cases are admitted to be rare. In cases of somewhat less intensity epithelial proliferation will take a larger share in the production of the consolidation, and there will be more marked change in the alveolar walls; whilst in those cases in which the inflammatory process is least intense and most chronic the growth in the alveolar walls and interlobular tissue will be most prominent.

The third lecture discusses the pathology, etiology, varieties, and treatment of phthisis, and shows that the author's acquaintance with phthisis is as great clinically as it undoubtedly is pathologically, and the few remarks on treatment are at once scientific and suggestive. We can recommend this work to our readers as affording some firm footing to those who are still floundering in what has proved hitherto the most treacherous of pathological quagmires.

OUR LIBRARY TABLE.

Gonorrhœal Rheumatism. By HENRY PERCY POTTER, F.R.C.S., Surgical Registrar to St. Thomas's Hospital. 8vo, 20 pp. London: Spottiswoode and Co. 1878.—Twenty cases of gonorrhœal rheumatism having occurred in the surgical practice of St. Thomas's Hospital during the year 1878, Mr. Potter has grouped them in a tabular form, and has added a few general remarks upon the affection. He has not been able, from his observation of these cases, to throw new light upon the pathological or clinical history of the disease; but the reader will find the main facts already known clearly and concisely stated in this pamphlet. The author seems to us, however, to have overlooked the main cause of the infrequency with which the female sex is attacked with rheumatism during the course of a gonorrhœa. He attributes it "to the comparative thickness of the vaginal mucous membrane, or to the absence in many cases of urethritis." Surely he might have added with truth, that an inflammation of the short, simple tube of the female is far less likely to lead to constitutional mischief than the same affection of the long and complex canal of the male. And this brings us face to face with the question, Is the rheumatic affection due to the special form of disease of the

urethra, or to the fact that it is an affection of this particular organ? We think that facts point rather to the latter conclusion. The influence of sex is one such fact; whilst another of still greater weight is that the irritation of the urethra by the simple passage of a catheter is sometimes sufficient to cause quite similar joint trouble, without lighting up urethritis. The belief in the specific nature of gonorrhœa is fast losing ground, if it has not already entirely disappeared in England; and we believe that gonorrhœal rheumatism will ere long be known as urethral rheumatism, and be no more adduced as proof of the specific or constitutional nature of what is usually a simple and local disease.

Notes on Rheumatism. By JULIUS POLLOCK, M.D. Second Edition. J. & A. Churchill. 1879.—The second edition of this little work differs from the first mainly in the addition of a chapter on the chemistry and mode of action of salicin, salicylic acid, and salicylate of soda, with an appendix of illustrative cases. The merits of the book are in inverse proportion to its size, and it may be especially commended to practitioners.

Ozone in relation to Health and Disease. By H. DAY, M.D. London: Churchills. — The chief facts concerning ozone have been carefully studied and lucidly arranged by Dr. Day, so as to make this pamphlet very pleasant and profitable reading. To those who wish to learn something concerning ozone, especially in its relation to health and disease, but who have not time to devote to the systematic study of the subject, we commend the perusal of this *brochure*. Its twenty-four pages abound with solid and useful information.

Essentials of Chemistry, Inorganic and Organic, for the Use of Students in Medicine. By R. A. WITTHAUS, A.M., M.D., Professor of Chemistry in the Medical Department, University of Vermont, &c. New York: William Wood and Co. 1879.—A small catechism on the plan formerly so popular in schools. It appears fairly accurate, but we fail to see any special merit that it possesses.

THE TROOPS IN CYPRUS.

Two papers have recently been presented to Parliament relative to the health of the troops in Cyprus. The first is a return, giving the strength of each description of force employed, and the numbers sick in them on every Friday from the date of occupation till the 10th of January last; and the second, a copy of a report of the Principal Medical Officer on the health of the troops. We had anticipated that the latter, furnished by the officer who for several years was head of the Statistical Branch of the Army Medical Department, would have given such numerical details as would have thrown considerable light on the extent and nature of the sickness from which the troops suffered so severely; but in this we have been disappointed. The military force employed consisted partly of British and partly of native Indian troops. Of the latter no information, or at least scarcely any, is given. As Sir A. D. Home was principal medical officer of the whole force, he must, of course, have received weekly returns from the Indian contingent; and we are quite unable to understand upon what principle all the details relative to it have been omitted. But even as regards the British troops no tabular statement has been furnished of the admissions into hospital and deaths by the different classes of diseases, and the report does not contain the slightest reference to the Royal Artillery beyond the statement that the F Battery, 2nd Brigade, came to Cyprus from India. As regards the Royal Engineers also, although allusion is made to the sickly condition of some of the detachments, no information is given as to the sickness and mortality of the whole.

We may briefly summarise the information on these points as follows:—The 101st Regiment served in the island 78 days; its average strength was 813 men, who furnished 841 admissions into hospital and 5 deaths. The 42nd Regiment served 119 days; its strength was 727 men; admissions 1258, deaths 12. The 71st Regiment was 146 days on the island, and had an average strength of 724 men, with 1083 admissions and 5 deaths. The annual ratio of admissions and deaths per 1000 of mean strength is stated in the report to have been as follows:—

42nd Regiment,	4264	admissions,	40·68	deaths per	1000
71st	,,	3242	,,	14·97	,,
101st	,,	4082	,,	24·27	,,

The report does not furnish data from which to calculate the sickness and mortality of the Royal Artillery, Royal Engineers, or the total force. The report is also remarkable for the absence of all reference to the number non-effective from sickness—a most important subject from a military point of view. This information is, however, given in the return above alluded to. From it we learn that the average strength of British troops from July 26th to January 10th was 1886; of Indian troops from July 19th to October 11th 1336; of marines, from July 12th to December 27th, 145; and of sailors for the same period 904. The average proportion constantly non-effective from sickness per 1000 of strength was 97·4 English soldiers, 62·7 Indian soldiers, 32·3 marines, and 47·4 sailors. We have no information as to how or where the marines and sailors were quartered, or whether they were frequently relieved from the ships, so that no accurate comparison can be instituted between them and the troops. We merely direct attention to their marked relative exemption from sickness, in the hope that it may call forth some explanation from those who are acquainted with the details. The return shows that on the average of the period included in it one-tenth of the European soldiers were constantly non-effective from sickness, but this does not correctly represent the extent to which the force was thus disabled. In the week ending August 16th the inefficiency from sickness amounted to one-fifth of the English soldiers, and during the four weeks ending Sept. 13th, 20th, and 27th, and Oct. 4th, it was one-eighth. The principal cause of this high proportion of sickness was fever, in the early period of the remittent type, giving place to the intermittent as the hot season passed away. As we have already pointed out, no numerical statement is furnished of the admissions and deaths by the various classes of disease.

The Principal Medical Officer states in his report that the troops landed on the evening of July 22nd, and were encamped on "a plain near the sea at Cheflik Pasha, about five miles south-west of Larnaca. From a military point of view it was very suitable for the purpose. ..... Nor, regarded from a sanitary point of view, could the ground selected be regarded at first sight as ineligible." This opinion is scarcely borne out by a statement which follows: "The sea was nearly two miles off, but there was a large salt-water lagoon between it and the east border of the camp." And again: "About half-way between Larnaca and Cheflik there was an extensive salt-water lagoon; and nearer the camp, the water escaping from the aqueduct at one point found its way to the sea through sodden rush-covered ground." About ten days after the troops landed the admissions into hospital became very numerous, the 101st and 42nd Regiments furnishing a considerably larger number of cases than the 71st; the comparative exemption of the latter was supposed to be due to the somewhat higher ground occupied by it, and its greater distance from the low land near the salt marsh, but it was maintained throughout the whole period of service in the island. In consequence of the great sickness the troops were moved to other camps, and these again were changed when the men became sickly in them. It is unnecessary to detail the various changes, which have been fully recorded in the report before us. It may be sufficient to state that the removal seemed to be beneficial at first in every instance, but this was very soon succeeded by a large increase of sickness. It was not till the last week of October that a decided improvement took place; "it marked the turning-point between the healthy and unhealthy season, between the excessive and moderate prevalence of the endemic illness." The 101st Regiment left Cyprus on Oct. 8th, the 42nd Regiment on Nov. 18th, and the 71st on Dec. 15th. The 1st Batt. 20th Regiment, which relieved the latter, enjoyed excellent health, the average constantly sick having been only 33 per 1000.

The sickly condition of the troops throughout the summer and autumn appears to have been caused by malaria combined with great solar heat, cold nights, excessive moisture manifested by heavy dew at night and dense mist in the morning. "There was often a difference of 40° between the highest day and lowest night temperatures." To these may probably be added, though not specified in the report, the emanations arising from turning up the soil in the road-making and in the formation of the various camps. It is certainly remarkable that all the changes of locality appear in the first instance to have been attended with a reduction in the amount of sickness, to be followed in a few days by a marked increase. The tents were mostly of the ordinary bell-shape, quite unsuited to shelter the men from the great solar heat, the temperature in them rising to 113° in the hottest part of the day. In addition to these causes, there were the very indifferent quality of the meat and the inadequate means of cooking. We cannot be surprised at the sickly condition of the troops under such unfavourable circumstances. The military and medical authorities appear to have exerted themselves to ameliorate the condition of the men, but with very indifferent success. The sickness did not abate till the cool weather set in and the troops were provided with adequate shelter in huts. The Principal Medical Officer is of opinion that if sent out between the middle of November and the middle of February, and then properly lodged, fed, and clothed, "under these easily satisfied conditions" troops might be stationed at a selected place in the hills of Cyprus with every prospect of their being healthy and efficient. If this be so, what must we say as to the responsibility of those who sent them out last summer without any one of these conditions being fulfilled?

We regret that we have been compelled to speak in terms of depreciation of the report before us. It does not come up at all to what we should have expected from Sir A. Home, and we can only hope that he has prepared for the head of his department one which will give in full detail all the information that can be desired relative to the extent and character of the sickness which prevailed among the troops generally and the individual constituent portions of the force, the causes of this sickness, the means employed to avert it, and the degree of success or failure which attended these. We have yet to wait for a satisfactory medical history of the military occupation of Cyprus, and we trust that such may in due time be forthcoming from the Army Medical Department.

REPORTS OF MEDICAL OFFICERS OF HEALTH.

THE reports of the medical officer of health, for the year 1878, of the Craven combined sanitary district in Yorkshire, Dr. Fred. W. Barry, are remarkable for the evidence they afford of thorough work. Including the general report, and one special report, they are ten in number. Each of the several sanitary districts (eight) entering into the combined district is reported upon separately, while the general state of the district is discussed in an independent report. The special report refers to the sanitary condition of a separate village, which is dealt with in detail, and we understand that this is to be the model upon which Dr. Barry proposes to report upon the villages and towns of his district. Obviously Dr. Barry has unbounded confidence in his capacity for work, and is determined not to rest until every particular agency harmful to the health of the population of his district is brought into the fullest light. Craven, with such a worker, should become as distinguished for its sanitary condition as for its natural beauties.

Dr. Anningson, the medical officer of health for Cambridge, in his annual report for 1878, expresses himself as dissatisfied with a death-rate of 19·66 per 1000 for the year, the birth-rate declining. There is room, he thinks, for the borough, or, more accurately, "improvement district," to have a still lower mortality, and he congratulates the local board on the activity they are displaying in lessening acknowledged sanitary evils.

The medical officer of health for Bradford, Yorkshire (Mr. Butterfield), in his report for 1878, states that the death-rate of the borough—22·5 per 1000 population—was lower in that year than in the two previous years. The report contains much of interest relating to the detailed sanitary work of the borough.

The annual report for 1878 of the medical officer of health to the Epping rural sanitary authority (Mr. Trevor Fowler) shows a death-rate of 15·4 and a birth-rate of 27·0 per 1000 population for the year. The average annual death-rate of the district for the five years 1874–78 was 15·8, and the birth-rate 28·7.

The annual report (the first) of the medical officer of the Thingoe rural sanitary district (Suffolk) for 1878 (Mr. Charles Scott Kilner) shows a death-rate of 12·5 and a birth-rate of 28·2 during the year. Even the low death-rate here recorded cannot, according to the information in the report, be regarded as indicating the whole health capacity of the district. It is, in fact, a higher rate than need be in this district, and, if Mr. Kilner's excellent advice be given heed to, Thingoe may presently return a still lower rate of mortality.

The annual report of the medical officer of health of Dundee for 1878 (Dr. Pirrie), recently issued, presents little for special observation. Uneventful years do not lend themselves to the preparation of interesting reports; and, happily for Dundee, 1878 appears to have been an uneventful year in the health-history of that burgh. The death-rate of the burgh for the year was 21·56 per 1000, a slight increase over the death-rate of 1877; and the birth-rate was 33·56 per 1000, a decrease as compared with that of the previous year—a result, Dr. Pirrie observes, due to a diminution of the population, and to the commercial depression which persisted throughout the year. The death-rate, with the exception of that of Greenock, was the lowest observed during the year among the principal towns of Scotland. The slight excess of mortality in the burgh appears to have been occasioned by a somewhat larger prevalence of diseases of the zymotic class than had taken place in 1877. The annual report of the sanitary inspector, Mr. Kinnear, is published in conjunction with that of Dr. Pirrie, and gives evidence of the care with which the sanitary details of the burgh are considered.

Dr. Whitmore makes a curious complaint in his last monthly report. It relates to the unreasonable calls made upon the time of the sanitary officers of the parish by well-to-do householders wishful to have the health-condition of their houses examined. The time which has to be thus given to the requirements of persons presumably quite able to secure competent help at their own cost affects detrimentally the work of the sanitary officers as relates to the houses occupied by parishioners who are unable to obtain such help, and which Dr. Whitmore thinks have a primary claim on the sanitary authority. The question thus raised is not without difficulty, and we hope it may be discussed by the Marylebone vestry.

ARSENICAL POISONING FROM WALL-PAPERS, ETC.

THE following is a copy of the queries issued to the members of the profession by Mr. Malcolm Morris (of 63, Montague-square, W.), hon. secretary to the committee recently appointed by the Medical Society of London to investigate the subject of arsenical poisoning by means of wall-papers, paint, articles of furniture, and wearing apparel:—

1. Have you had under your observation, during the last five years, any cases clearly traceable to arsenical poisoning, produced by wall-papers, paint, articles of furniture, or wearing apparel, &c.?
2. Any cases previous to that time?
3. What were the first symptoms that led you to suspect this form of poisoning?
4. State briefly the prominent characteristics of each case.
5. Were there any external symptoms of irritation?
6. How long was it in each case before the patient recovered health and strength?
7. Were any cases fatal?
8. What article contained the poison? What tests were employed to detect its presence?
9. How many cases occurred in men? How many in women? How many in children?

THE LANCET.

LONDON: SATURDAY, MAY 31, 1879.

IN our number of the 17th inst. we pointed out that the Committee of the Medico-Chirurgical Society had committed themselves in their report to the view that there were classes of cases of membranous laryngitis distinct from those caused by contagious diphtheria, but that they had failed to indicate any criteria by which such cases could be distinguished, pathologically or clinically, from membranous laryngitis of diphtheritic origin. Inasmuch as no distinctive features could be laid down by the Committee by which idiopathic membranous laryngitis can be separated from the laryngeal form of diphtheria, we must agree with Mr. PARKER that the *onus probandi* now lies with those who believe in the non-identity of the two diseases. In adducing evidence on this point, it is absolutely essential that the cases should not merely have a diagnostic label, such as "membranous croup" attached to them, but that their etiology, symptoms, and course be thoroughly investigated, and that they are cases of membranous laryngitis purely and simply be assured by a post-mortem examination and a histological investigation into the characters of the membrane. The necessity of such minute and careful observation is shown by the fact that, although until recently almost every medical man in the kingdom believed that membranous laryngitis was generally caused by cold, yet not a single case in which it followed a definite exposure was sent in to the Committee, in spite of their urgent appeals, and the five hospital cases in which this is ascribed as a cause are by no means free from the suspicion of some other antecedent, especially when they are read by the side of the remarkable cases narrated by Dr. JOHNSON and Dr. FITZPATRICK. In these the disease appeared at first sight to be due to cold, but on further inquiry it was found to be due to impregnation of air or water with sewer gas. Dr. GREENFIELD'S report on the membrane in Dr. REID'S case of eau de Cologne inhalation, in which the specimen materially differed from that formed in ordinary cases of membranous exudation into the larynx, shows how a careful examination will often remove from discussion a case that was apparently destined to become classical. Again, in Dr. POORE'S case, in which the expulsion of a membrane apparently followed an exposure to the east wind, the membrane proved to be an hydatid; and in Dr. SANSOM'S example of idiopathic membranous croup, the membrane was shown to be simply coagulated muco-pus. Not only therefore must we have conclusive evidence of the existence of a false membrane in the larynx, but the microscopical characters of the membrane or cast must also be carefully recorded, before the case can be deemed of any value in the elucidation of the problem. None of the cases which were brought before the Committee or mentioned during the discussion, as affording support to the non-identity theory, would bear the rigid scrutiny we have indicated, so that the replies to the circular, and the speeches, have to be considered merely as the expression of facts viewed through the medium of opinions, rather than as facts on which definite conclusions could be based. The Committee therefore acted most wisely in not dogmatising on the insufficient data before them, but leaving the question open for future investigation and research. The report is very valuable, because it indicates clearly the gaps in our knowledge of a disease or diseases in whose existence most practitioners, following too blindly the beliefs and opinions of their teachers and predecessors, can scarcely bring themselves to believe. The possible non-existence of a membranous laryngitis, apart from diphtheria, is so startling a proposition, that we find many of the speakers treating it as a heresy, which they are astonished that men otherwise well-informed in the profession can seriously urge. And yet we are sure that those who have carefully considered the question, untrammeled by traditional teaching and unbiased by the opinions of a former generation, whose means of testing the truth of the doctrines entertained by them were very limited in comparison with those at our disposal now, will feel, with Sir WM. JENNER, that instead of the weight of evidence being in favour of the non-identity of the two diseases, it is very much inclined in the other direction. The prevalent opinion in the profession that we have settled the matter when we speak of the one disease—membranous croup—as sthenic, and always requiring depressing remedies, such as local bloodletting, mercury, and antimony; the other disease—laryngeal diphtheria—as asthenic, and always needing support by brandy and huge doses of perchloride of iron, cannot be too quickly removed, for even if we allow that membranous laryngitis may arise from a variety of causes, we must also insist on the fact that the affection may be sthenic or asthenic in type, and so necessitate a careful investigation of the individual case, and not be treated on a mere routine plan associated in our minds with the name we may happen to give to the disease.

Another point of great importance in the report is that definite meanings are attached to the words "croup" and "diphtheria." We had hoped that the Committee would have laid down such definitions as would have removed all ambiguity in the future use of the words, but we regret that they have not succeeded in so doing. In speaking of croup, we are told that "it is a semeiotic term, relating to lesion of function; and, provided we keep within this principle, we may try to improve the current definitions of the word." So, after an interesting review of the complex notion which the term signifies, the following definition is suggested:—"Croup is an acute febrile primary spontaneous *angina laryngea*, occurring for the most part in children." This merely restates CULLEN'S description of *cynanche trachealis*, with a little more precision, but with less clearness, and is a useless refinement. It would have been much better if, instead of attempting to improve the word "croup," to which so many erroneous ideas cling, the Committee had proposed its abolition, for we should then be spared endless disquisitions as to whether spasmodic croup differed from inflammatory croup, and false croup from true croup, in essence or degree. What useful purpose is served by a mere verbal discussion on whether there be one, two, or three kinds of croup, when the word is a barbarism signifying nothing but a peculiar modification of the

breathing, voice, and cough, which may come on in any laryngeal disease, or even in diseases outside the larynx which implicate its nervous supply. The meaning of "croupy" as an adjective is well known and sufficiently definite to describe a certain set of symptoms, but to persist in the use of the noun as the name of any special disease or group of diseases will only perpetuate our present confusion. The proposed definition of the word *diphtheria*, which BRETONNEAU wisely refrained from attempting, seems to us equally liable to produce confusion. At page 30 we are told that "diphtheria is a specific inflammation of mucous membrane or of excoriated skin," and that the diagnosis of a diphtheritic pellicular inflammation depends on two kinds of data: first, positive — viz., the presence of an epidemic,—that is to say, of the diphtheritic virus; secondly, negative—viz., by exclusion of other diseases which are sometimes attended by pellicular inflammations of mucous membrane, such as common membranous angina, scarlet fever, &c. The uselessness of such a definition, and the confusion arising therefrom, are shown both in the report and in the discussion. At page 33 the word is used in quite a different and much better sense—viz., "as an anatomical definition of a zymotic disease which may or may not be attended with croup"; and at page 4 the same Committee which define so positively what diphtheria is tell us that one of the most embarrassing points in the inquiry is the anomalous position which it holds in the rank of zymotic diseases, and the difficulty of defining what is and what is not diphtheria. Thus, in the discussion, the views of Mr. HUTCHINSON and Dr. WILKS on the diphtheritic nature of epidemic sore-throat; of Dr. JOHNSON and Dr. DICKINSON, who believe in the origin of diphtheria *de novo* as a result of poisoning by sewer-gas; and of Dr. THORNE THORNE, who considers that it is now in course of development as a specific disease, and is acquiring stability by repeated propagation,—are so completely at variance with the definition of the Committee that we are sorry to find such an exact and precise limitation of the term (much more so than the present state of our knowledge warrants) supported by the authority of the Committee, and in a report which must be referred to by all future inquirers into the subject.

SUBJECT to appeal, the Court of Queen's Bench has decided that the case of the Hampstead Hospital must be newly tried, on the ground that the verdict of the jury in the previous trial was against the evidence, and also founded on misdirection. This verdict was, in effect, that the hospital was a nuisance *per se*, and that, at all events, if not so, it was rendered so by the absence of due care on the part of the authorities. The question whether there is a right of action against the hospital has still to be heard in the Court of Appeal, and there also will be carried this decision of the Queen's Bench. Pending, however, the result of the appeals, it may not be amiss to indicate a cardinal error into which the managers of the hospital fell in defending their case on the first trial, and which most contributed to the decision being adverse to them. The matter concerns not only the immediate questions which will have to be dealt with by the managers of the Hampstead Hospital in the event of a new trial, but it concerns the managers of every small-pox hospital, and indeed infectious disease hospital, throughout the kingdom.

The Lord Chief Justice, in giving judgment on the recent application for a new trial in the case of the Hampstead Hospital, laid down with great clearness the directions which it would be requisite to give to a jury in submitting to them the question whether a small-pox hospital were a nuisance or not. To create a nuisance from the presence of a hospital, danger to health from the alleged nuisance must, he said, be shown. It is only if the jury shall arrive at the conclusion that there is such a danger from the presence of the hospital that the owner of the adjoining property can be entitled to maintain an action against it. It is not sufficient to show that there is an interference with his comfort, or the enjoyment of his property, even although it had caused a diminution of its value. That, said the Lord Chief Justice, is not enough to constitute a nuisance, unless there is a well-founded and reasonable apprehension of danger from the presence of such an establishment.

Now there can be no doubt that the jury, in the first trial of this case, were chiefly influenced in their verdict by the belief that the evidence tendered by the plaintiffs afforded proof of a well-founded and reasonable apprehension of danger from the Hampstead Hospital; it is equally undoubted that the evidence tendered by the managers to the contrary was astonishing for its insufficiency. This was the more remarkable, for the plaintiffs' evidence as to danger, where not fallacious, was so "purely speculative — one might say imaginative" (to use the Attorney-General's words)—that, as their case proceeded, it appeared as if they were playing into the hands of the managers. But when the evidence to the contrary was produced, it was found to be a greater curiosity of insufficiency for its purpose than the evidence of the plaintiffs had been for their purpose. This was the more extraordinary because the question of the danger from the hospital to the adjoining houses had been almost constantly before the public for six years or more; the facts from which danger was inferred admitted, it is to be presumed, of being carefully investigated as they happened; there was not a statement of the plaintiffs as to the alleged danger which probably could not have been dealt with precisely on its particular merits in relation to the hospital; yet the managers elected to treat them as if they were mere matters of opinion, and to confront averment with averment, and not averment with evidence of actual facts. Indeed, from early in the case it seemed as if the managers were so sure that on legal grounds a case could not hold against them, that they were indifferent to that aspect of the case which most interested the public and most influenced the jury.

Even if there should be a new trial, and the verdict of the jury be reversed, it will be long before the mischievous effects of that verdict on the erection of infectious hospitals will be exhausted. It is a misfortune that the question of infectious disease hospitals as dangerous to health should have been raised in a court of law in connexion with a hospital which is a poor-law, and not a sanitary, hospital. The result as affecting public feeling would be the same to whichever form of administration the hospital belonged, but the position of the defendants would be very different. The Hampstead

Hospital was constructed for poor-law purposes, is under poor-law management, and has only in an indirect manner any public-health function to perform. Thus its managers have no defined responsibility for its public-health bearings, are not called upon to defend it from a public-health point of view, and there is reason to believe that they have too exclusively restricted their attention for the interests of the hospital to matters within its precincts, indifferent to matters without. They were not called upon, and it was no part of their duty, to deal with the public-health aspect of the question, and this, in consequence, was not presented at the trial. The conditions under which infectious-disease hospitals are built — such as are empowered to be erected by the Public Health Act, 1875,— differ very considerably from those under which poor-law hospitals are erected and managed, and the evidence accessible in relation to them would, it is highly probable, have materially modified the conclusions of the jury as to the dangers of infectious-disease hospitals, if properly set before them. As it is, the infectious-disease hospitals belonging to sanitary authorities—"sanitary hospitals," as they have been aptly termed—must suffer in reputation from a verdict in a case which has no proper parallelism with them. It seems as if it were destined that poor-law administration should be the bane of public-health administration.

Managers of "sanitary hospitals," who can have no excuse for not keeping watch upon the influence of their hospital upon the health of neighbouring dwellings, will do well not to allow any alleged injury to health from the hospital to remain without precise inquiry and careful record. If the results of such inquiry had been produced in the Hampstead Hospital case, as they ought to have been, we have no doubt that the allegation of the hospital being a nuisance *per se* would have been completely disproved.

THE reply Mr. DILLWYN elicited from Mr. Secretary CROSS on the 22nd inst., to the effect that the Lord Chancellor is prepared to submit a measure, or measures, of Lunacy Law Reform to the Legislature, and only waits a favourable opportunity, renders it increasingly important that the question should be considered "urgent," and settled with the least possible delay. As matters now stand, the proprietors, lessees, and officers of licensed houses are kept in a state of suspense, which cannot fail to prove injurious to the interests of their patients. It is, manifestly, unreasonable to expect that more money will be honestly invested in what are called "retreats" for the paying classes until the terms of the tenure on which such property is henceforth to be held are clearly and finally determined. We can foresee how speculative investments, with a view to compensation, might be provoked by the present position of the subject, but delay cannot operate otherwise than injuriously on the minds of the most respectable proprietors. As Dr. BODINGTON, speaking in the name of the holders of licensed houses for the insane, contended at a recent meeting, called by the Midland Medical Society, the history of private asylums is the history of lunacy practice. Beyond question, special institutions, adapted for the requirements of patients who have been accustomed to select society, and are provided with sufficient means to defray the cost of special comforts, are necessary. Husbands, wives, and parents, must be in a position to place the object of their solicitude under a particular physician, and at a house of their own selection, and it follows that, so far as the public is concerned, matters must remain very much as at present. The reform needed is such transfer of the immediate financial interests from proprietors and superintendents as shall relieve these gentlemen from the suspicion of receiving, or detaining, patients improperly, to their own advantage; and finally set at rest a frequently active source of disquietude, which operates prejudicially on the public mind.

We are anxious that our own position in this matter should be clearly understood. It has been repeatedly stated in these columns that we do not urge reform on the ground that there have been abuses of the system it is desired to change. Every case of alleged grievance or injury submitted to the Select Committee, and described as arising out of the system of "private asylums," broke down. In the course of our own investigations we have not met with any instance of malpractice, nor have we any reason to believe that wrong is done although it may not be proved. We have nothing to say against the keepers of licensed houses, or to urge in prejudice of the position they occupy, except what was asserted by the founder of this journal in the House of Commons as far back as the year 1841, and which is as true now as it was then—namely, that the system does not supply those in charge of lunatics with any motive to cure. We simply reaffirm this proposition, and on precisely the same grounds which induced the member for Finsbury to lay it down—namely, that it is not for the credit of the medical profession that a considerable, though numerically small, body of its members should occupy a false position; and it is, certainly, opposed to the interests and progress in mental medicine that the treatment of disease should be handicapped with the commercial enterprise of "hotel-keeping," albeit the hostel kept for the accommodation of patients is necessarily of a special kind. The argument we have adduced against the licensed-house system is based solely on these premisses, with the further consideration that it is not in accordance with the spirit of the constitution, or with social prudence, that the right of imprisonment should be entrusted to private persons. Only officers acting in the name and by the authority of the State should be empowered to enforce restraint of any description, or to assume custody of the person. There is a monstrous anomaly, if not actual insecurity, in a system which authorises any near "friend" of an alleged lunatic to usurp supreme control of the person of the patient and to thrust him into a madhouse, if only he can obtain certificates of insanity from two medical men, who may, or may not, be competent to form an opinion on the case submitted to them. The immediate effect of being forced, or lured, into an asylum is so likely to act prejudicially on the mind of a weakly individual, that it is incumbent on the Legislature to reform this altogether. Other matters of detail may be left to the consideration of Parliament, when, if ever, it takes the subject seriously in hand.

Our chief purpose at the present conjuncture is to protest against further delay. Surely the subject has been debated —we might say thrashed—sufficiently. It is high time it should be rescued from the toils of the agitators. No indis-

position, but, on the contrary, entire willingness, has been shown by the medical proprietors of licensed houses to meet public opinion on fair terms in any impartial and properly conducted deliberation. It is, indeed, questioned whether the public are really interested in the question of Lunacy Law reform. We have of late frequently heard the assertion that all the agitation has been got up by a few writers in the press. This is a matter respecting which we have no information. For ourselves, we can only point to the continuous line of argument THE LANCET has pursued in relation to "private asylums" during the last forty years. We believe that public opinion is at length very much in earnest in the matter, and without saying how or by what specific reform, we feel strongly that the time has arrived when the existing system *must* be reformed. If there were no more urgent reason for change, the fact that the position of *medical* proprietors, lessees, and superintendents of licensed houses has been blown upon, would be sufficient to make the profession desire reform. It is impossible to avoid the feeling that the repute of the medical body as a whole is involved in this question, and it is a simple duty to submit that an adequate proposal should be made to Parliament, and a final adjustment of the issue which has been raised attempted without delay. We are unable to support the detailed suggestions embodied in Mr. DILLWYN'S Bill. In some respects they go too far, as, for example, when it is proposed to make a justice of the peace party to the diagnosis of a case of disease. It is manifestly impossible the lay magistrate can know as much of lunacy as any average medical man would know, so that the substitution of a justice for a practitioner must lessen the medical security; while if the attestation is wanted to insure the good faith of the medical certifier, setting aside the gratuitous insult involved in the proposal, there must be a loss of security, because two men acting independently are likely to be a better check on each other than the mere presence of a magistrate can be. In other respects the Bill does not go far enough. Nevertheless, we hail Mr. DILLWYN'S intervention as a contribution to the cause of peace in this matter, and we trust the rejoinder of the Home Secretary may not be found to presage the further postponement of a really urgent question until that convenient season which, as a matter of experience in politics, seldom comes until the outside pressure of reformers and grievance-mongers is felt to be irresistible, and compels the attention it is desired to delay.

OUR attention has lately been recalled to the subject of sick sailors abroad by the recent issue of a Blue-book entitled Hospitals in Foreign Ports, in continuation of one with the same heading that appeared in the summer of 1877, on the motion of Mr. STANHOPE, political secretary to the Board of Trade. The object of these two somewhat voluminous documents, consisting mostly of correspondence between the Foreign Office, the Board of Trade, and our consuls at certain ports in Europe and South America, is to show the sort of accommodation provided for British sailors when they arrive sick, or become sick during the stay of the vessel in the country. Ports abroad may be divided into three classes: (1) those where no hospital exists for British seamen; (2) those where there is a native hospital only; (3) those where the hospital used by foreign seamen is a foreign (e.g., a British) hospital exclusively. It is not necessary to go at length into the evidence adduced; the sum and substance of it is that, as a rule, the treatment of British sailors in native hospitals where natives and others also are treated, is unsatisfactory, with our own sailors exceedingly unpopular, and, financially considered, rather costly, all ships being taxed for what is looked upon as a somewhat inadequate *quid pro quo*. At ports where there is no hospital for seamen, "the charges are often heavy, and the skill of the practitioners uncertain," as private practitioners, of course, have to be consulted. At ports where there are hospitals more or less under the protection of the British Government—e.g., in the Ottoman empire, a tax is levied, which at Constantinople and Smyrna has succeeded admirably, as no complaint has ever been made as to the burden of the charges or the inadequacy of the hospital accommodation. At Pernambuco, Rio, Cronstadt, Monte Video, and Buenos Ayres, where Her Britannic Majesty has no power to levy local taxes, a system of voluntary rating has been tried, but with very varying success. At Cronstadt and Buenos Ayres it has been successful, in the former instance on account of the efforts of resident merchants and shipmasters, aided by contributions from Her Majesty's Government, and in the latter by the benevolent spirit of the residents. It is clear, however, that, to flourish in any port, such institutions should, by some means or other, be made self-supporting. As soon as it is known that the tax is voluntary, the inferior class of shipmasters decline to pay unless sickness actually exists on board. We draw public attention to this subject because it brings out yet another among many good reasons that exist for instituting medical inspection of seamen before signing articles. The transport of sick and worn-out seamen home from foreign ports now costs the State from £30,000 to £40,000 annually, mainly because so many men sign articles who are physically unfit for duty afloat. These are the men who help to fill hospitals abroad, and for whom mainly indeed such places have to be maintained. In urging the Board of Trade to assist in keeping up hospitals for British seamen at foreign ports, either by direct subscription or by requesting foreign Governments to permit a system of taxation, we only ask for the establishment of a remedy for an acknowledged evil. And as long as the Board of Trade decline to make a modified medical inspection of seamen compulsory, and so save the pockets of ratepayers generally and those of shipowners in particular, it is the manifest duty of that department to assist in supporting places abroad where the sailor can be treated skilfully and quickly, and so return to his ship sufficiently cured to do duty; or, if the case be really hopeless, that he may be forwarded to his home as speedily as possible, procrastination in such matters, of course, meaning expense to the State, the shipowner, or the sailor himself. But the real antidote, as now acknowledged by shipowners and shipmasters, is a well-organised and well-conducted but compulsory medical examination at the port of departure.

ANOTHER successful case of transfusion of milk has taken place in one of the Dublin hospitals.

Annotations.

"Ne quid nimis."

THE SELECT COMMITTEE.

THE Select Committee on the Bills for the Amendment of the Medical Act (1858) is to be nominated on Monday, June 9th, or, to speak more safely, the nomination is among the notices of motion for that day. The names are as follows:—Mr. William Edward Forster, Dr. Cameron, Mr. Dalrymple, Mr. Errington, Mr. Goldney, Mr. Heygate, Lord George Hamilton, Sir Trevor Laurence, Dr. Lush, Mr. Mitchell Henry, Mr. Arthur Mills, Dr. Lyon Playfair, Mr. Serjeant Simon, Mr. David Plunket, and Mr. Wheelhouse; the Committee to have power to examine witnesses and send for papers, five to be the quorum. The constitution of the Committee seems to be satisfactory; it includes fifteen names, eight from the Conservative and seven from the Liberal side of the House; three medical men, Dr. Lush, Dr. Cameron, and Mr. Mitchell Henry. No less than four of the fifteen members represent Medical Bills which are to be considered by the Committee, all of them contemplating the amendment of the Medical Act, but in various ways and degrees, which we shall hope to notice more particularly next week. It ought to be within the power of such a committee to suggest those reasonable changes which are called for by public opinion in the constitution of those bodies which regulate the admission of persons to the medical profession.

DOUBLE DISTAL LIGATURE FOR AORTIC ANEURISM.

MR. BARWELL is certainly to be congratulated on the success with which he has carried out the surgical treatment of aortic and innominate aneurism. Of five cases in which he has performed double distal ligature—of the carotid and subclavian—four have recovered from the operation, and have obtained more or less benefit from the treatment. This success stands alone in surgical records. The difficulties hitherto surrounding this practice have been many—that of precise diagnosis, the widespread arterial disease often extending to the arteries in the neck, concomitant disease of the heart and other viscera, and that of understanding *how* the treatment proves successful. We may reasonably hope that at least some of these difficulties may be overcome. Careful physical examination, combined with the use of the sphygmograph, promises to make diagnosis certain; the use of ligatures which do not sever any of the coats of the arteries may render the operation much safer, and the collection of cases in which it has been performed without immediately fatal results will demonstrate what it is capable of accomplishing, and when, therefore, it may be recommended. In his paper at the Medical and Chirurgical Society, Mr. Barwell advanced a new theory to explain the success of the distal ligature, and to guide the surgeon in the choice of the side on which to operate. He believes that there are two currents of blood in the aorta of different degrees of rapidity—one on the right, the slower, to the innominate trunk; the other on the left, the more rapid, to the left subclavian and carotid. When, therefore, the aneurism is on the right side of the aorta, the right branches should be ligatured, and when on the left side of the aorta the left vessels should be tied. Mr. Barwell does not adduce much evidence in support of this theory, and many objections may be raised against it. How is this difference in the rate of the two currents produced? If it exist, the pulse in the vessels of the left side of the head, neck, and arm should be in advance of that on the right side. And if embola are carried up the left carotid artery because that is the quickest part of the stream, of course the solid blood-corpuscles will be governed by the same physical law, and will be found more numerous on the left than on the right side of the head and face. Nor had Mr. Barwell much corroborative evidence in the case he related. He stated that the pulse on the two sides was equal, but if the aneurism was affecting only the right stream of blood in the aorta, this should have been indicated by a marked departure from the normal on the right side only. We cannot, therefore, accept this theory unless its truth can be demonstrated, or these objections answered, and further evidence in its favour adduced. No definite opinion can be expressed upon Mr. Barwell's new ligature until it has been more fully tried, although we may say that it promises well. It may be that it does not divide any of the coats of the artery, but it must be borne in mind that if the coats are much compressed only, that part will die, and cause the ultimate division of the vessel, and with more than the usual danger. Mr. Barwell spoke as if the mere occlusion of an artery causes coagulation; but this is not so, the blood remains fluid so long as the vessel retains its full vitality; no doubt the unused artery will gradually shrink, and may ultimately become obliterated. What we want especially to know, therefore, is what becomes of this ligature. Is it absorbed and replaced by a ring of fibrous tissue? Or does it remain in the tissues unaltered? Under the existing state of the law we shall have to wait long for an answer to this question, or get it from abroad.

FIELD HOSPITALS IN INDIA.

A RECENT General Order of the Government of India sanctions the formation of field hospitals on the "general system" for troops employed on active service in that country, and authorises the *précis* of "Field Medical Arrangements" compiled under the orders of Surgeon-General Ker Innes, C.B., to be adopted in carrying out the working details of that system. This *précis* was drawn up at the commencement of the present Afghan war for the use of the troops then about to take the field, and the lines of medical organisation laid down therein have been followed more or less in the three columns engaged in Afghanistan. The difficulties of introducing a new and, in India, untried system have not been few or easily overcome. Obstruction was met with on all sides. The military body, as a rule, were opposed to any change; the dual system of medical administration threw obstacles in its path; yet, wherever the system has had a fair trial, it has, by the energy, firmness, and tact on the part of the medical officers connected with it, surmounted every difficulty. General and commanding officers of both services have given a verdict in its favour, not only for the large economy in medical equipments, establishments, and, above all, transport, but in the actual gain to the sick and wounded soldier in the shape of better provision for his care and comfort. This has been pointed out from time to time in our correspondent's letters during the progress of the war now happily terminated in Afghanistan. The following extract from a letter, written by a medical officer of wide experience in the field, fully endorses the favourable opinions that have been expressed in our columns as to the advantages of the "general" over the regimental hospital system. The former has now stood the test of actual experience in warfare:—"Kandahar, February, 1879. Since I have been connected with the divisional hospitals, I have found that the system has worked well; in fact, I can't see how there can be two opinions between it and the regimental. I consider it admirably suited for the active service of this country, and well adapted in every particular to meet any peculiarity that may arise. Of course, the difficulty has been transport, more particularly in evacuating sick to the base hospitals.

We have had many difficulties to contend with in a new system being instituted in the middle, as it were, of active operations; still, with all that, I give my verdict that, let the system be stated fairly, and it is as nearly perfect as anything can be."

THE EDINBURGH UNIVERSITY CLUB.

THIS pleasant club had a very auspicious dinner at the Grosvenor Gallery on Tuesday last, his Royal Highness the Duke of Edinburgh, President of the club, occupying the chair. About 170 sat down to dinner, including many distinguished guests or graduates, amongst others Lord Houghton, Mr. William Spottiswoode, President of the Royal Society, Dr. Risdon Bennett, Mr. Simon, the American Minister, General Sir D. Lysons, Admiral Sir J. Hay, Mr. Boehm, Mr. Wemyss Reid, Mr. Christopher Heath, Mr. G. Augustus Sala, &c. Dinner being at eight, and the programme of the evening including a selection of music from "H.M.S. *Pinafore*," beautifully executed by Dr. Lavies and his friends, some of the toasts had to be omitted, and others to be lightly treated. The numbers dining, too, seemed a little in excess of the capacity of the waiters. But these are slight matters in a meeting where rank and science and art and learning were so affluently represented. His Royal Highness referred with pleasure to his student days in the University of Edinburgh. To the members, not the least grateful part of his speech was a feeling allusion to the loss the club has sustained by the recent death of Dr. Murchison, who, he said, had but lately been appointed physician to his brother, the Duke of Connaught, and who was one of the earliest and most devoted members of the club.

THE AUDIOMETER.

AT the last meeting of the Royal Society, Dr. Richardson demonstrated the action of a new instrument which he has named the audimeter, or audiometer, and which has just been invented by Professor Hughes, the discoverer of the microphone. The audiometer is used as a precise measurer of the sense of hearing. It is formed of a small battery of one or two Leclanché cells, a new microphonic key, two fixed primary coils, a graduated insulated bar, to which at each end one of the fixed coils is attached, a secondary induction coil, which moves along the graduated bar, and a telephone, the terminals of which are connected with the terminals of the induction coil.

The principle of the audiometer is based on the physical fact that when the battery is in action, and a current is passing through the two primary coils, the secondary coil on the bar becomes charged, by induction, whenever it is brought near to either of the primary coils; but when it is brought to the precise centre between the primary coils there is a neutral point, or electrical balance, where the electric phenomena from induction cease to be manifested. By placing a microphonic key between the battery and one of the primary coils, and by attaching the terminals of the induction coil to the telephone, Professor Hughes was able to make the telephone produce sounds whenever he brought the induction coil near to one of the primary coils and moved the microphonic key so as to make it play on a fine needle suspended in the circuit. When the induction coil is close to one of the primary coils, the noise is very loud, but as the coil is moved towards the centre of the bar the noise diminishes, until it ceases at the centre altogether. The scale on the bar is graduated into two hundred degrees, representing units of sounds from 200 to 0, or zero. At 200 all who can hear at all can hear the vibration of the drum in the telephone. At 0 no one can hear, while between the two points there are two hundred gradations of sound, from the highest down to zero.

In using the instrument, the telephone is put to the ear of the listener while the operator moves the microphonic key, and at the same time shifts the induction coil on the graduated bar so as to measure the hearing power of the person under examination. Dr. Richardson presented a preliminary report to the Royal Society on his first experiments with the audiometer, and showed that already, by its means, some useful and practical as well as curious facts had been obtained. Amongst many of these was one relating to an inquiry as to the best material for making artificial tympanums and the best form of artificial tympanums for cases of defective hearing from perforation or destruction of the natural drum. He had found gold made into the form of little cups or capsules exceedingly effective for this purpose. The audiometer promises to become one of those useful adjuncts to practice of which we shall say ultimately, How did we get on before it was known?

COUNTER-ATTRACTIONS.

FOREMOST among the measures of public policy tending to promote sobriety will, we believe, be found to stand the extensive provision of bars and taverns, readily accessible and conducted as nearly as possible in accord with the custom of the licensed victuallers, at which beverages that are not intoxicating shall be kept on sale. Tea and coffee are not perfectly satisfactory articles of drink, and in a technical sense they are as much drugs as fermented liquors, but compared with the latter, their properties are innocuous. The multiplication of tea and coffee taverns is consequently to be hailed as a movement of the highest social value, and one that worthily claims the support of the right-minded. The enterprise cannot succeed unless it be conducted on strictly commercial principles. The poor man will not tamely submit to be "deprived" of his beer, nor will he accept in lieu thereof a cup of tea or coffee bestowed as a bounty. As Lord Cairns very wisely pointed out, the commodities sold at these taverns must be offered at their full market value, not below it. The sole aim should be to re-educate the taste of the masses by placing by the side of the pernicious drinks one which is pleasant and wholesome, and which, having been fairly tried, is likely to be preferred. We have full faith in the judgment of the masses, if only the means of comparison can be placed before them; and we venture to urge that, in carrying out the scheme, the new taverns should be constructed and conducted after the fashion of the best gin-palaces and drinking-bars, and the return to habits of sobriety facilitated by the avoidance of all needless restrictions on the manners of those who resort to them. If to the tea and coffee tavern is to be added a teaching and preaching establishment, the opportunity will be lost. Let not an enterprise of genuine philanthropy which promises so well as this one does be ruined by the injudicious zeal or proselytising proclivities of those who engage in it. What we want is a tavern into which the drunkard may reel with the view of getting a cup of tea to sober him, and, taking his ease at the inn, come again and again, until the taste for a harmless drink replaces the vicious appetite. If this is possible, these taverns will succeed and do lasting good, but not otherwise.

Another movement in which we are much interested is the creation of harmless and interesting attractions outside the public-houses for evening entertainment and on Sundays. All these things would make for bodily and mental health. It is a short-sighted policy in the interests of morals and sobriety not to open the museums and picture galleries after dark and on the Sunday. Sooner or later this concession must be made, if not as a cause, then as a consequence, of greater enlightenment on the part of the people. Music-halls and theatres are crowded because places of resort which are kept up at the national expense are closed at the only times when the bulk of the labouring population could

use them. Sunday is a day of gloom for all who have not pleasant homes in which to lounge, and do not care to spend the hours in churches, chapels, or meeting-rooms. Within the last few years a fashion, much to be commended, has sprung into existence of substituting open bars for shutters in shop fronts. The economical advantages of this plan as a mode of advertisement must be obvious to every tradesman, and the effect is to lighten and brighten the streets, while providing the eye with something to gaze upon and the mind with subjects for thought. This is an admirable arrangement, and we venture to hope tradesmen will soon generally recognise the policy of adopting it. We have no reason to expect, or ground to hope, that the plan of exposing wares on view, though not for sale, will be pursued from any regard to the public convenience or enjoyment; but it is, happily, the fact that shops thus protected are safer both as respects risks from fire and robbery than those hidden behind close shutters. Therefore, we anticipate that the better method will be preferred, and the public streets converted into museums which are not open to the objection of keeping attendants unwillingly employed. If the people are to be led pleasantly back to those paths of innocence which are believed to have been once natural to men, it will be necessary to waive Puritanical objections; and we trust before long to find that which still lingers in certain quarters against the opening of museums, libraries, and picture galleries on Sunday among the first to succumb. We wish the tea and coffee taverns and this Sunday enlivening movement prompt and brilliant success.

THE JUNCTION OF FREE AND PROVIDENT DISPENSARIES.

A PROPOSAL to effect a conjunction of the Hastings Free Dispensary and the Hastings Provident Dispensary has been discussed at a special meeting of the governors of the former institution, and has been rejected by the large majority of 18 to 4. The amendment, which was carried, averred that the proposal was not in accordance with the original foundation of the institution; that, being a free dispensary, and entirely supported by voluntary aid, it would not work with a provident dispensary, which was self-supporting; thirdly, that the poor would not receive the assistance they are entitled to. The arguments, we are bound to say, were all on the side of the minority. It was shown that there was nothing in the rules against the junction. It is not correct that free dispensaries are all and always supported entirely by voluntary subscriptions. It is still less correct to say that provident dispensaries are all self-supporting. We only know of one that is—namely, the Rugeley Dispensary. Thirdly, it has to be proved that the poor will be neglected under such a system. The system has been tried in Leicester and elsewhere, and works well. It was unfortunate, we think, that the change had to be advocated chiefly by the medical officers of the institution, who were, of course, open to the easy but ungenerous remark that they were actuated by regard not for the patients but for themselves, and that if they did not find themselves able to do the work younger men would be found both able and willing. Nevertheless, their arguments were unassailable, and, in the end, must prevail, as "honest poverty" and the right treatment of it come to be better understood. The number of free dispensaries in which the patients are required to make some contribution to the expenses is great and increasing. On the other hand, provident dispensaries are still helped largely and very valuably by the wisely charitable. The question of conjunction is simply one of expediency. The advantages of conjunction are that the patients who are not provident will be tempted to become so by seeing its advantages, and that while abuses are pointed out as they arise no real hardship will be allowed to the really poor, or in urgent cases. We are not surprised, under the circumstances, to learn that the medical staff have deemed it expedient to resign, while they have volunteered their services for a month, that the poor may not suffer.

RISKS THROUGH SCHOOLING.

THE dangers encountered in our ordinary diet we know, and it is not the fault of those who delight in making life burdensome, by reason of the measures to be taken for its preservation, if we are not duly impressed with the perils which beset us in connexion with dress, the toilet, and even unguarded respiration. Meanwhile, a source of mischief, to which most middle-class families are exposed, is overlooked. We allude to the risk of infection by diseases, ranging from influenza to small-pox, from "sore-throat" to diphtheria, which are disseminated by children attending day-schools, and in this way enter a large proportion of households. No doubt the sufferers by this form of recklessness find their revenge in following the usual custom and sending back their children—with some passing excuse for non-attendance—after even a severe bout of illness; but this does not lessen the evil to which we point. It is one of no small magnitude, and to its existence much of the "illness" that weighs so heavily on the heads of families may be traced, with here and there cases of the greatest gravity, and even fatal in result. It would, doubtless, be considered a revolutionary proposal to suggest that private day-schools should be inspected. We have not yet finally convinced ourselves that it is expedient to supervise the health of public day-schools! Short of this measure, something might surely be done by making the keepers of day schools responsible for the spread of disease through their establishments. If it were recognised as a misdemeanour to allow children who may be sickening for any malady, or who have not perfectly recovered from an infectious disease, to be present in a school, some means would be taken by school managers and masters and mistresses to minimise the evil. It is not, obviously, possible to live in the world and mix in society without incurring many risks, but that is no reason why the number should be multiplied by the disregard of obvious precautions.

HEREDITARY TRANSMISSION.

AT the meeting of the Société de Biologie on April 17th, M. Brown-Séquard made an interesting communication on the subject of the hereditary transmission of peculiarities accidentally acquired, describing several new facts in corroboration of those to which he called attention long ago. He has met with guinea-pigs born with two digits instead of three, the parents having bitten off a digit during epileptiform attacks. The hereditary transmission of acquired epilepsy in his guinea-pigs is well known. He found also that precisely the same phenomena occur in the offspring which indicate the reunion of the divided sciatic in the parents, showing that the nerve is capable, as an effect of heredity, of passing through all the morbid states which result from its section. Exophthalmos may also be observed in the offspring when this has resulted from section of the restiform body in the parents, and the prominence of the eyeballs may occur on both sides, and may continue for four or five generations. Matznis has shown that the offspring of rabbits in which the spleen has been excised may be born without a spleen. M. Brown-Séquard mentioned the history of a man who, in consequence of an injury, had a peculiar deformity of the lower jaw, which reappeared in his three daughters; and also the remarkable case of a gentleman who had lost the middle finger of the right hand. His son presented no defect, but had two children, in both of whom the corresponding finger was absent. In another

case a man had had a finger of one hand amputated, and in a son, born four years after the accident, two fingers were wanting.

Remarkable as are these instances of hereditary transmission of defect, other phenomena of heredity are still more remarkable. The variation in the seat of a defect in the offspring is illustrated by the case of the increase of exophthalmos from unilateral in the parent to bilateral in the offspring. Three guinea-pigs were shown, in the father of which the sciatic nerve had been divided, leading to permanent paralysis. One of the young ones had paralysis of the corresponding paw, but in another the paw on the other side was paralysed. The animal appears to inherit, not the external lesion, but a peculiar condition of nervous system which determines the effect.

Even more mysterious, and less known, are the cases in which an acquired defect leads, in the offspring, not to a defect, but to an excess of the corresponding part. The offspring of a guinea-pig in which one toe has been removed may be born with a supernumerary toe. If a certain point of one restiform body be divided, a series of ecchymoses commonly appear upon the ear on the corresponding side, and a smaller number of ecchymoses upon the ear on the opposite side. These spots dry, a gangrene occurs, and the edge of the ear breaks down into powder. Dr. Brown-Séquard presented a guinea-pig in which this effect had occurred. In this animal, however, the change had not taken place, as usually happens, within a fortnight, but more than four months later; so that, had the animal not been preserved, the conclusion would have been reached that the effect had not been produced. This guinea-pig had had three young ones, and one of these presented upon one ear two supplementary appendices on the dorsal aspect. The second presented a defect of part of one ear on the side opposite to the defect in the parent. The third presented an ecchymosis on one ear at the time of birth—the first condition of the lesion. Later two ecchymoses appeared—not at the border of the ear, but at a little distance; and the interstitial hæmorrhage was followed by gangrene and a fall of the tissues. In the discussion which followed Dr. Brown-Séquard's communication, M. Rouget mentioned a similar observation in the case of the salamander, as regards the individual—namely, the growth of two tails when one had been amputated.

THE CLINICAL SOCIETY.

THERE could not be a clearer instance of the unwisdom of drawing comparisons with insufficient data than was afforded at the last meeting of the Clinical Society, in the discussion on the treatment of genu valgum. Mr. Brodhurst endeavoured to show that he could accomplish by other and safer means all the good results claimed for osteotomy. But he adduced insufficient evidence in support of each of his assertions. The case he exhibited was evidently incomplete, an apparatus and crutches being still necessary to enable the patient to walk, and it was therefore premature to speak confidently of the ultimate result. It was subsequently affirmed that there was only one case on record where any ill result had followed division of the internal condyle for genu valgum, and Mr. Brodhurst's statement that he had seen many cases where anchylosis or effusion or suppuration had occurred was not sufficient to set aside that statement. In his reply to questions asking for further particulars of these unfortunate cases he did not give any, not even their exact number, and stated that they had all occurred in his private practice, and he was therefore unable to bring them before the Society. We have yet to become acquainted with any operation uniformly attended with only good results, and we have no such hopes of osteotomy; but truth will not be established by loose statements such as those to which we refer; rather will it be hidden. We trust this question will soon be cleared up, and we would point out that it is the imperative duty of surgeons practising this operation to make public the exact results of it, especially if they meet with any bad ones. This may require courage, and some sacrifice of personal feeling, but in that way alone can truth be arrived at.

TRAINED NURSES.

EVERY medical man will be ready to admit the great help given in the treatment of serious cases by trained nurses. It adds much to the chances of success in many cases, especially those of fever and those of severe surgical operations, notably that of ovariotomy. Even in many cases where life is not to be saved or disease to be cured, suffering is greatly mitigated by good nursing. In the homes of poor patients it is amazing to see the difference made by the presence of a trained nurse for half an hour once or twice a day—an advantage which, in various parts of London, medical men can now secure for their humblest patients by sending a line to the offices of the Metropolitan Association for Nursing the Poor. It would be unreasonable to expect nurses to be perfect. Occasionally there is a little defect in the power of adaptation to individual cases and moods—a certain harshness in the application of rules and instructions. But the fault is often as much one of training as personal. It is natural that nurses who have to obey a certain set of instructions should appear a little mechanical and unsympathetic in doing so. It is for those who train them to impress on nurses the fact that human nature is a very various thing, and has to be greatly considered and humoured in the weak moments of pain and suffering.

OPIUM v. ALCOHOL.

A STATEMENT, on good authority, has recently been made to the effect that during the last two years the consumption of opium by the working classes has considerably increased; and an explanation has been advanced that this increased consumption has been induced by the restriction of the sale of intoxicating liquors by the early closing of public-houses under the late Act. That the sale of narcotic drugs has of late greatly increased we fear there is but little reason to doubt; but that the explanation offered is the correct one, we feel bound to demur to. The persons resorting to alcohol or opium for the sake of obtaining temporary relief from their sorrows, pains, and anxieties are not the ordinary frequenters of the public-house. The patrons of these are generally the social sots, not the careworn and miserable, who prefer to take their solace alone. It is rather to the hardness of the times than to any restraint in the sale of drink that the increased consumption of opium by the working classes is to be attributed. Opium is cheaper than alcohol, and twopence expended on the former will give more present ease than sixpennyworth of the latter. Nor when first commenced does its use produce such unpleasant after-effects as an intoxicating dose of alcohol. It is sad to learn that the sale of opium is extending among the lower classes, and we hope, if the evil be found to be gaining ground with the rapidity stated — and from facts before us we cannot doubt the accuracy of the report in the main,—that Government will take action in the matter, and place severe restrictions on the sale of all narcotic drugs. By doing so not only would many be prevented from falling into the snare, but those who have commenced the deadly habit would be reclaimed by the impossibility of obtaining the drug without the cognisance of their friends. No such difficulty exists with regard to this question as with respect to restrictions on the sale of alcohol. The free employment of narcotic drugs has wrought individual evil enough among

the upper and middle classes of society, but it would be a national disaster if their use continued to extend among our working classes.

THE DANGERS OF OUR FOOD SUPPLY.

IN spite of all legislative efforts and the activity of sanitary inspectors, our peace of mind is constantly disturbed by startling and disgusting revelations concerning the food we eat. That which should give strength and health and repair the waste of tissue is, on the contrary, often the medium for the introduction of disease. One day is discovered a costermonger's stock—fruit, fish, or vegetables, stored under a filthy bed where a patient lies ill with fever. Now the sanitary inspector of the Whitechapel district reports that he has found fifty live fowls closely packed together in a cupboard of a ground floor, causing a most offensive smell. Their owner, who lived in a neighbouring street, had some more fowls in his bedroom, while in another house a foreigner kept forty fowls in a room heated by a large coke fire. This fire probably made the fowls lay abundantly, but the heat also greatly intensified the bad odour. Revisiting this place at midnight the inspector found several persons sleeping in the room with about a hundred dead fowls close to them ready trussed for sale! Though the presence of live poultry in a dirty and crowded room is at once disgusting and dangerous, the storing of large quantities of dead birds in such a place is even more objectionable. Should not the sale of food be restricted to those who have a proper place for its preservation? An enormous proportion of the food sold in the streets of London is kept at night in costermongers' bedrooms. It would be inexpedient and extremely difficult to do away with this large body of peripatetic tradesmen; but, in the reconstruction of condemned quarters, dwellings might be built with cellarage for the benefit of this class, where they would be compelled to store whatever stock they might have remaining on hand when the day's work is over.

THE MIDDLESEX HOSPITAL.

THE two senior officers on the honorary medical staff of the Middlesex Hospital have retired this week, both after a long period of active and zealous service in the institution. Many years ago Mr. T. W. Nunn was well known as an anatomical teacher at the school with which he has always been identified. He became assistant-surgeon to the hospital, and has been full surgeon for ten years, having for some time prior to his promotion acted as extra surgeon. Dr. Henry Thompson has been physician to the hospital for twenty years, having been elected to that office after a service of three years as assistant-physician. Their colleagues, and all those who have enjoyed the benefit of their teaching and example, must naturally feel the loss entailed by their retirement from hospital work. So long and honourable a connexion cannot be allowed to terminate without our bearing testimony to the manner in which these gentlemen have, for so long a time, consistently and assiduously performed the duties required of them; and we may venture to express the hope that they may attain the objects they have in view in retiring at this time.

THE SANITARY STATE OF KENSINGTON.

DR. ORME DUDFIELD'S various reports on the health of Kensington have quite a special position among the reports of the several medical officers of the metropolis. Their interest is by no means limited to questions peculiarly affecting the health of Kensington. While dealing very fully with local matters as more particularly touching his duty, he never loses sight of the fact that Kensington, except by an arbitrary distinction for the purposes of local administration, cannot be dissociated from other parts of the metropolis in its sanitary relations, and as a consequence he has accustomed himself to discuss at large the questions relating to the community of sanitary interests among the metropolitan local authorities of the metropolis. Hence his reports, while primarily dealing with the health of his district, deal also with the questions which concern the health of the metropolis as a whole, and so form a most interesting and instructive history, as it were, of metropolitan sanitary movement. These remarks are suggested by the publication of Dr. Dudfield's annual report for 1878. It consists, as we think wisely, of a reissue, under one cover, of his several monthly and special reports for the year, together with a brief summary of the vital statistics of Kensington. The report is of value beyond its local interest, for from it may be obtained very conveniently and readily an account of the various questions concerning the public health of the metropolis generally which have been mooted during the year.

HER MAJESTY'S LEVEE.

THE following members of the medical profession were present at the *levée* on the 26th, held by H.R.H. the Prince of Wales on behalf of Her Majesty the Queen. *Presentations:* Dr. James Irving, Dr. George Hastings, Surgeon-Major P. Jameson, Surgeon-Major C. M. Jessop, Surgeon-Major T. J. Orton, and Surgeon J. Maitland, Madras Service. *Attended:* Surgeon-General T. Longmore, C.B., Deputy Surgeon-General W. A. Mackinnon, C.B., Mr. White Cooper, Dr. R. Quain, Dr. R. Farquharson, Dr. P. Frank, Surgeon-Major Alfred Clark, and Surgeon-General John Murray, Bengal Medical Service.

MEDICAL OFFICERS OF PRISONS IN IRELAND.

WITH reference to the paragraph in our last week's issue on the formal announcement by the chairman of the Irish Prisons Board to the surgeons of county infirmaries acting as medical officers of prisons, that their posts are vacant, we learn that at a recent meeting of the College of Physicians in Ireland a resolution was adopted to the effect that by the action of the authorities a grievous wrong would be inflicted on the medical officers in question, and that the circular was a violation of the principles contended for by the College in 1876, and conceded by the Chief Secretary for Ireland while the Prisons (Ireland) Bill was passing through Parliament, and embodied in the Prisons Act.

THE ROYAL MEDICAL BENEVOLENT COLLEGE.

AT the annual meeting of this institution, held on Thursday afternoon, resolutions were put and carried by a large majority, requesting, in effect, the Council to alter the bye-laws in such a manner as to leave candidates to be recommended by a special committee of selection. We shall refer to the subject more fully next week, and meanwhile congratulate the governors on their well-earned success, after a struggle of three years' duration.

PAUPER ACCOMMODATION AT ST. GEORGE'S-IN-THE-EAST.

WE have had occasion to complain in these columns of the bad accommodation given to the paupers in the workhouse of St. George's-in-the-East, and our remarks excited the indignation of the local authorities. It appears, however, that the Local Government Board has now entered a complaint against the condition of the casual wards of this same district. The state of the beds and coverings was far from satisfactory, and the ward was in need of cleansing and whitewashing. We trust that the care thus bestowed on the able-bodied tramps who frequent the casual ward will not be wanting to protect those whose ailments give them a better claim to our sympathy, and who are confined to the

wards of the workhouse which have been used for infirmary purposes, though they are not at all suited to serve as a pauper hospital.

IT was resolved by the students of St. Thomas's Hospital, at a general meeting held on May 9th, that a memorial should be raised to the late Dr. Murchison as a token of their gratitude for his labours as a clinical teacher, and that all past and present students, as well as others interested in the scheme, be asked to subscribe. If sufficient funds are obtained it is proposed to place a bust of Dr. Murchison in the hall of St. Thomas's Hospital, or to erect some other suitable memorial. Subscriptions will be received by the hon. secs., W. H. Battle and T. D. Acland, at St. Thomas's Hospital. P.O. orders to be made payable to W. H. Battle, at the Westminster-bridge-road Office; cheques payable to the Murchison Memorial Fund, to be crossed London and County Bank.

WE regret to report the death, on May 4th, at Dinapore, Bengal, of Surgeon-Major Patrick Joseph Clarke, Army Medical Department. Mr. Clarke entered the service as Assistant-Surgeon in March, 1848, served throughout the Crimean campaign (medal and clasp and Turkish medal), was promoted Surgeon in May, 1855, served in India during the mutiny, was present at the siege of Lucknow (medal), and attained the rank of Surgeon-Major in September, 1869.

SURGEON-MAJORS J. HECTOR and D. RENTON, Army Medical Department, are under orders for Natal; the former proceeds in command of the detachment of the Army Hospital Corps, embarking in the *Euphrates;* Mr. Renton taking medical charge of the troops in the *Queen Margaret* transport.

DEPUTY SURGEON-GENERAL SIR ANTHONY D. HOME, V.C., K.C.B., has been appointed Principal Medical Officer of the Northern District at York, *vice* Surgeon-General D. Mackinnon, transferred to Aldershot on promotion.

THE INFLUENCE OF MARRIAGE UPON THE RATE OF MORTALITY.

A WELL-KNOWN French savant, Dr. Bertillon, has published a long and careful essay upon what he terms "nuptiality, or the conjunctive attraction of human couples," and the result at which he arrives, after a study of the mortality bills of every country in Europe, is that marriage is without exception conducive to length of life, and that Molière was indeed right when he said, "Il vaut encore mieux être marié que mort." Some of the statistics quoted by Dr. Bertillon are so striking that they will be read with interest. Dr. Bertillon has taken several European countries as examples in support of his theory, and in his first chapter he deals with Holland, where, owing to the existence of a law of divorce, he is able to form what may be called three classes of marriageable people—viz., bachelors and spinsters, married men and women, and divorced persons. Upon the side of the males he finds that for young men between the ages of twenty-two and twenty-four the annual number of marriages is at the rate of 46 per 1000, and that for widowers of that age the rate is 213 per 1000, while between the ages of twenty-five and thirty-five bachelors marry at the rate of 100 and widowers at the rate of 356 per 1000. The number of divorced men who marry again is, between the ages of thirty and thirty-five, 50 per cent. in excess of the rate of bachelors, and the proportion goes on increasing up to the age of forty-five, when it is six times greater than that of bachelor marriages.

With regard to females, the statistics quoted by Dr. Bertillon show that in Holland, while the annual number of marriages of spinsters aged from eighteen to twenty-one is 22 per 1000, widows of the same ages re-marry at the rate of 44 per 1000. Between the ages of twenty-five and twenty-nine spinsters marry at the rate of 115 per 1000, and widows at the rate of 157 per 1000. Upon the other hand, there are proportionately fewer marriages of divorced women than of spinsters up to the age of thirty, but after that age the proportion increases, and at forty exceeds that of either spinsters or widows. The figures differ more or less with regard to France, England, Belgium, and Germany, but in all cases they show that the marriage of widowers and widows, and of divorced people in the countries where the law of divorce exists, is proportionately much more frequent than that of bachelors and spinsters.

The most interesting part of Dr. Bertillon's essay, however, is that which is devoted to proving by figures that marriage is conducive to longevity, and is, so to speak, an insurance against disease, crime, and suicide. He arrives at the conclusion that "a bachelor of twenty-five is not a better life than a married man of forty-five; that among widowers of from twenty-five to thirty the rate of mortality is as great as among married men of from fifty-five to sixty." In other words, that celibacy ages a young man at least twenty years, and widowhood still more. Taking the French bills of mortality, he shows that while the annual rate of death among married men between twenty and twenty-five years of age is rather under 10 per 1000, bachelors of that age die at the rate of 16 and widows of 19 per 1000. These are the figures for the whole of France, while taking Paris more particularly it appears that the rate for men of those ages is 15·7 per 1000 for married men, 27 per 1000 for bachelors, and 32 per 1000 for widowers. Between the ages of thirty and thirty-five the rate of mortality is 69 per cent. greater among bachelors, and 281 per cent. among widowers, than it is among married men, and the difference goes on increasing the further one advances in life. With regard to women the contrary is the case, for in France the mortality of spinsters between the ages of forty and forty-five is 30 per cent. higher than that of married women, while between the ages of twenty and twenty-five the proportions are almost reversed. This is, no doubt, to be explained by the number of young married women who die in childbed.

A state of widowhood is, according to Dr. Bertillon, even more prejudicial to men than to women, the probability of death being twice or even three times as great as among married men of the same age, while up to twenty-five it is four times as great. So, again, with regard to crime; Dr. Bertillon asserts that for males offences against the person are 50 per cent. fewer, and offences against property 45 per cent. fewer, among the married than among the unmarried. The difference is still more remarkable among women, amounting to 250 per cent., and this is attributed to the restraining influence of the husband. Equally striking are the figures which show that crime and suicide, less frequent among married than unmarried persons, are still less frequent among married people with than without families, and the natural inference to be drawn is that the duty of providing for their children makes even the thoughtless better members of society than they otherwise would be. The number of suicides is at the rate of 628 per million for widowers, 273 per million for bachelors, and 246 per million for married men; while the same proportion holds good of widows, spinsters, and married women, though at a somewhat reduced rate for each of the three categories; because, as a commentator of Dr. Bertillon's statistics unkindly remarks, "women have less feeling than men." Dr. Bertillon finds that married people suffer less from disease of every kind than unmarried ones, and he states that pulmonary consumption carries off twice as many widowers as married men of the same age at all periods of life.

It is unnecessary to quote at greater length from these statistics, all which tend to the same conclusion—namely, that marriage is conducive to health, long life, and morality. Dr. Bertillon argues that the true reason for the lower mortality and the higher morality of married people is that marriage makes people lead more regular lives and take more care of themselves than those who have no such tie, and that the excess of mortality among widowers and widows, as compared even with bachelors and spinsters, is due to the fact that, as a rule, they relapse into irregular habits.

HEALTH OF LARGE ENGLISH TOWNS
IN THE TWENTY-FIRST WEEK OF 1879.

DURING last week 4972 births and 3029 deaths were registered in twenty of the largest English towns. The births were 210, and the deaths 341, below the average weekly number during 1878. The deaths showed a further decrease of 145 from the declining numbers in recent weeks. The annual rate per 1000, which in the eleven preceding weeks had declined from 29·1 to 22·4, further fell last week to 21·4. The lowest ratio in those towns last week were, 16·3 in Brighton, 17·0 in Leicester, 17·4 in Bristol, and 18·2 in Portsmouth. The ratio in the other towns ranged upwards to 23·8 in Liverpool, 24·41 in Manchester, 24·6 in Salford, and 25·1 in Norwich. The high rate in Salford was in great measure due to the excessive fatality of zymotic diseases. The high rates in Liverpool, Manchester, and Norwich appear, however, to have been mainly caused by the mortality from diseases of the respiratory organs. The fatality of lung diseases continues to show a considerable excess, although it has declined rapidly in recent weeks. The deaths referred last week to the seven principal zymotic diseases in the twenty towns were 365, and showed a slight increase upon the low number returned in the previous week; they included 109 from whooping-cough, 79 from scarlet fever 75 from measles, and 38 from fever, principally enteric. The annual death-rate from these seven diseases averaged 2·6 per 1000 in the twenty towns; it was 0·0 in both Brighton and Plymouth, whereas it ranged upwards to 3·5 and 4·0 in Salford and Sheffield. Whooping-cough showed the largest proportional fatality in Sheffield, Birmingham, and Salford, scarlet fever in Newcastle-upon-Tyne, and measles in Salford. Two deaths were referred to diphtheria in both Birmingham and Sunderland. Small-pox caused 17 more deaths in London, but not one in any of the nineteen large provincial towns; indeed in those nineteen towns which have an aggregate population somewhat exceeding that of London, only one fatal case of small-pox has been recorded since the beginning of the year, against 311 in London. In Dublin, with less than a tenth of the population of London, 316 deaths from small-pox have been registered since the 1st of January last.

Correspondence.

"Audi alteram partem."

CASE OF BULLET-WOUND OF THE ANTERIOR LOBES OF THE BRAIN.

To the Editor of THE LANCET.

SIR,—Mr. Thomas Smith's very rare case of bullet-wound of the anterior lobes of the brain, recorded in THE LANCET May 3rd, is of great interest to physicians on account of its bearings on the pathology of aphasia and upon the question of cerebral localisation. The bullet appears to have passed through the head from temple to temple, perforating the anterior lobes of the brain. In his comments upon the case Mr. Smith remarks:—"I am not aware that any case has yet been recorded of recovery after perforation of both frontal lobes of the brain." If he will be good enough to refer to Trousseau's classical paper on Aphasia (Clinical Medicine, New Sydenham Society's Translation, vol. i., p. 255) he will find an account of a case closely resembling his own in the nature and seat of the injury, and in the occurrence of recovery from the more immediate effects of the lesion. Reference is made to Trousseau's case by Dr. Ferrier in his admirable Gulstonian lectures on the localisation of cerebral disease in the following words:—"Trousseau gives a frequently quoted case of an officer who, in a duel, received a bullet, which passed through the head in the middle of the frontal lobes. The man could speak freely, and showed no signs of paralysis of any kind. Death occurred from encephalitis." It is true the patient died of encephalitis, the result of his injury, but for several months his recovery was apparently complete. On turning to Trousseau's narrative, a perusal of which suggests that Mr. Smith's patient may not yet, unhappily, be "out of the wood," I find that, in the spring of 1825, a French officer was shot by a pistol-ball, which entered his head "at one temple, passed through the brain, and then raised the temporal bone on the opposite side. Portions of the brain came out of the aperture of entrance. . . He was brought to the Tours hospital in a state of stupor. . . The left temporal muscle was divided, the piece of fractured bone raised with a spatula, and the ball extracted. . . . . After a few days the patient could speak, and was not paralysed in the least. At the end of a month he could get about, and during the five months which he spent in the hospital, living almost constantly in the company of the resident pupils, he amused them by his merry ways and his witty conversation, whilst he employed his leisure by writing comedies. Towards the close of the summer he complained of violent headache, and stupor supervened, with signs of acute cerebral softening; and on dissection, after death, a splinter of bone was found in the track of the ball, which had caused the inflammation of the cerebral tissue."

I am, Sir, yours faithfully,

Birmingham, May 5th, 1879. JAMES SAWYER.

COMPOUND ANÆSTHETIC MIXTURE.

To the Editor of THE LANCET.

SIR,—Allow me to inform you that for the last two years before and during the performance of capital operations at the Chesterfield Hospital we have almost invariably used the following anæsthetic mixture—viz., absolute alcohol, one part; chloroform, two parts; sulphuric ether, three parts. I believe it will be found to be safer than chloroform *per se*; and, as a rule, quicker in its action than sulphuric ether. It is especially useful in cases of feeble pulse and partial collapse, in which, nevertheless, immediate operative interference is imperative. Dr. Charles Bell Taylor, of Nottingham, writes me as follows:—"The above mixture was first recommended by the Chloroform Committee some ten years ago. I frequently use it, but don't know that it has any advantages over a few drops of chloroform applied to the ether mask when requisite during inhalation." I am inclined to form a higher opinion of it than this, and I recommend it to the notice of hospital surgeons.

Casualties from chloroform have lately been too frequent, and as the subject of anæsthetics is not yet exhausted, and is literally of vital importance, I send you this note.

I am, Sir, yours faithfully,

Chesterfield, May 24th, 1879. JOHN ROSE, M.D.

MIDWIVES AND CORONERS' JURIES.

To the Editor of THE LANCET.

SIR,—For some time past the attention of the public has been drawn to the proceedings of magisterial and coroners' investigations, and thinking the following case may interest your readers, I have ventured to ask you the favour of inserting this in the next number of THE LANCET.

I was called on April 5th, about 3 P.M., to see a woman aged forty, who, I was informed, was in labour, with a midwife in attendance. I proceeded to the house at once, and to my surprise found the poor woman dead. I questioned the midwife, and elicited the following facts:—The child had been born two hours when I arrived, and was healthy. She said the afterbirth came away about an hour after the birth of the child, but there was a "lump" she could not understand. Upon examining the "lump" I found it to be no less than the uterus completely inverted, forming a tumour as large as a child's head, and projecting four or five inches downwards between the thighs, with the placenta, or rather a considerable portion of it, adherent to the left wall. A portion, she said, she had torn off to see what the "lump" was.

Knowing this was a case for a coroner's jury, I at once communicated with the police, and was ordered to make a post-mortem, which I did, assisted by Dr. Eager, with this result:—All the organs of the body were healthy, with the exception that the lungs exhibited old-standing disease. She had suffered from chronic bronchitis for years. On examining the pelvic cavity, the uterus was wanting, and the

BEST COPY AVAILABLE

fingers could be passed down into the tumour between the thighs.

Now, Sir, I felt this to be a very important case, and not having met with inversion before, I consulted many members of the profession with the like result; consequently I looked up all the books I could on the subject, and fail to find that inversion takes place during labour, excepting directly after the expulsion of the child. This fact, together with the other evidence—viz., the length of time from the birth of the child to the birth of the placenta, its being adherent, and the statement that it was about an hour before the recovery of the placenta, also the general surroundings of the case—convinced me that inversion had taken place from the endeavour to bring away the placenta, which should have been done by introducing the hand into the uterus. This evidence I gave to the jury, and was supported by Dr. Eager. The jury returned a verdict of "Death from natural causes," and exonerated the midwife from blame.

Comment by me would be useless, if not dangerous, and I must leave that to my professional brethren, who I hope will state any cases of the kind they have met with, as they would be most instructive.

I trust, Sir, you will forgive the length of this letter. My excuse must be the importance of the subject.

I am, Sir, your obedient servant,

ROBERT A. SKINNER, M.R.C.S.E.

Woking Station, April 21, 1879.

COMPLETE TRANSPOSITION OF THE THORACIC AND ABDOMINAL VISCERA.

To the Editor of THE LANCET.

SIR,—As I believe recorded cases of complete transposition of the thoracic and abdominal viscera are sufficiently rare to be worthy of notice, I send you the following notes of an autopsy made by me on the 5th inst.

The man died from disease of the aortic valves, and on the only occasion on which I examined him before his death I diagnosed valve disease of the heart and transposition of the viscera. As the morbid appearances presented nothing of special interest I will trespass on your space with merely a description of the position of the viscera.

The heart was situated with its base behind the sternum, directed upwards, and to the *left*; its apex pointed downwards and to the *right*, and corresponded with a point about two inches and a half *directly* below the *right* nipple (the organ was enlarged, hence the apex was so far to the right).

The aorta wound over the root of the *right* lung, and descended along the *right* side of the bodies of the dorsal vertebræ. The arrangement of the branches of the arch was transposed, the subclavian and common carotid arising separately and supplying the *right* side, the innominate supplying the *left*. The branches arose from the arch from *right* to *left* in the order in which they are named.

Lungs: The *left* had *three* lobes, and was broader and shorter than the right. The right had only two lobes, and the lower part of its anterior border sloped downwards and to the *right*, leaving the pericardium uncovered; in fact, the normal lungs were transposed.

In the abdomen the large lobe (normally *right* lobe) of the liver was the *left* part of the gland, and occupied the *left* hypochondrium, and the right end (left lobe) extended into the *right* hypochondrium.

The stomach was situated in the *right* hypochondrium, with its greater end to the *right*. The descending portion of the duodenum was in front of the left kidney, the concave side of the gut being in close relation with the head of the pancreas, which was therefore the *left* extremity of that organ. The spleen was situated in the *right* hypochondrium, its concave surface looking inwards and to the *left*. The cæcum occupied the *left* iliac fossa, and the sigmoid flexure of the colon the right iliac fossa; consequently the ascending colon was on the *right* side, the descending colon on the left, and the course of the contents of the bowels through the transverse colon from left to right, the reverse of the normal direction.

I remain, Sir, yours faithfully,

J. NORMAN DAVIS, M.D.,
Surgeon-Major A.M.D.

Newbridge, Ireland, May 7th, 1879.

THE ARMY MEDICAL SERVICE.

To the Editor of THE LANCET.

SIR,—The following anecdote in Gleig's "Life of Wellington" may interest some of your readers, especially "P. M. J.", as it shows that in 1812, at any rate, the Army Medical Department was not accustomed to public notice.

After the capture of Badajoz, Dr. M'Grigor, making his report to Lord Wellington, asked if his lordship was satisfied with the conduct of the surgeons. "Perfectly," was the answer; "I saw with my own eyes that their exertions were superhuman." Dr. M'Grigor then proposed that they should be mentioned in the despatches by way of encouragement. Lord Wellington asked, abruptly, if that were usual; but promised to "add something about the doctors"; and this, the author adds, is the first instance of their being mentioned, "and the good custom then established has never since fallen into abeyance."

Yours faithfully,

May 17th, 1879. J. W.

THE STATISTICS OF THE BIRMINGHAM LYING-IN CHARITY.

To the Editor of THE LANCET.

SIR,—I trust that you will allow me to point out that the use you make of these statistics is open to a very important qualification. The Birmingham Lying-in Charity refuses all unmarried women, and even then it has a very disproportionately small number of primiparæ. As it thus removes the most important factors of puerperal mortality, its statistics can serve no legitimate purpose, but to display the multiparous mortality in the decent artisan class.

I am &c.,

Birmingham, May 27, 1879. LAWSON TAIT.

Obituary.

CHARLES BROOKE, M.A., F.R.C.S., F.R.S.

BY the death of Mr. Charles Brooke the profession has lost one of its most honoured members in the metropolis. He was a student of the now almost forgotten Windmill-street School of Medicine, and also of St. Bartholomew's. He long held a surgeonship in the Westminster Hospital, but had retired from the staff of the hospital and from practice several years before his death. He lectured for one or two sessions on Surgery at Dermott's School, having for colleagues the late Dr. Tyler Smith and Dr. Barnes. In 1844 the Royal College of Surgeons conferred upon him an honorary fellowship. He was, moreover, a graduate in Arts of Cambridge and wrangler, and a Fellow of the Royal Society. Mr. Brooke was best known to the profession and to the scientific world at large by his labours in physical science. To the medical men of the present generation he is chiefly known by his work, "The Elements of Natural Philosophy, or an Introduction to the Study of the Physical Sciences." This work forms one of the very best of Messrs. Churchill's series of Manuals, and although defaced by many badly-drawn illustrations, it is still unsurpassed as an elementary book. Originally written by Dr. Golding Bird, and particularly designed for the use of medical students, after having passed through three editions, "The Elements," on that physician's death, was entrusted to Mr. Brooke for editorship. The great progress which physical science had meanwhile undergone rendered it necessary to rewrite the work. The book lost nothing of its popularity in the process, while it was brought up to a higher level of thought without detriment to its original intention as a student's manual. Several editions of Mr. Brooke's "Elements" have appeared, and the book remains the best introductory work to the study of the physical sciences for the English student of medicine, if not for English students generally. At the present time, when there is a redundancy of text-books on natural philosophy, and when the draughtsman's and engraver's arts have been employed to the uttermost in enriching them with beautifully-drawn illustrations, the

abiding popularity of this shabbily-illustrated manual may be with some a matter of surprise. But the first edition of the book appeared before the epoch of elaborate and artistic illustration of text-books, when readers were content with illustrations which showed what the author desired to show independently of artistic merit, and when the literary merit of the work was the prime consideration. At that time the want of a text-book on natural science adapted to the requirements of the medical student was seriously felt. Dr. Golding Bird, from his large experience of students and their requirements at Guy's Hospital, accurately gauged the want, and so happily supplied it by the first edition of "The Elements" that the work at once became an unequivocal success, and that success was fully sustained in the ensuing editions from his own pen, and from the pen of his successor in the authorship, Mr. Brooke.

In the scientific world generally Mr. Brooke will, perhaps, be best remembered by his exquisite application of photography to the automatic registration, first of the variations of the magnetic needle, and subsequently of the fluctuations of the barometer and thermometer. The application to the registration of magnetic variations supplied a desideratum which had long been sought by scientific men, and for the discovery of which a premium had been offered by the Government. Mr. Brooke's method of registration was at once adopted and has since continued in use at the Royal Observatory, Greenwich, and shortly afterwards it was adopted also in the Paris Observatory. He was awarded the premium offered by the Government for the discovery, as also a Council medal by the jurors of the Great Exhibition, at which Exhibition one of Mr. Brooke's instruments for magnetic registration formed one of the most interesting of the many remarkable inventions thus brought together. He was also conspicuous for his microscopical work, and for several ingenious mechanical and optical improvements in the microscope.

So modest, so wanting in self-assertion was Charles Brooke, that his great merit and originality as a surgeon have been undeservedly overlooked. His "bead suture" was much more than a simple mechanical contrivance for securing sutures and keeping deep wounds in apposition. It was really the exponent of a great advance in a department of surgery at the time regarded by many as hopeless. He applied it—indeed, invented it—for the cure of lacerations of the perineum and of vesico-vaginal fistula. He carried out and perfected his operations whilst surgeon to the Metropolitan Free Hospital, forty years ago, and therefore long before the times of those surgeons with whose names these operations are more familiarly associated. The writer assisted at some of these operations, and can testify to their success and to the ingenuity and originality with which the difficulties were overcome. He used silk sutures, and there being no Sims's speculum in those days, he not only invented, but made with his own hands the most delicate instruments for exposing the parts, getting fresh surfaces, passing sutures, and tying knots at the fundus of the vagina. The bead sutures may be regarded as the originals of the various shields which have since been used. Looking impartially at what Brooke accomplished and what has been done since, it is difficult to find much of real importance that he left for others to do. He had to encounter and overcome greater difficulties than his successors who have forgotten his name.

He was a member of the Council of the Royal Botanic Society, and took a great interest in botany. It may not be altogether inappropriate to state, in connexion with his marvellously developed and cultivated mechanical dexterity, that he was one of the crack skaters of London. He was one of the most honest, amiable, and lovable of men. His genial greeting and unfailing readiness to help with his scientific knowledge will be long missed.

WILLIAM STUART, M.D., M.R.C.S.

DR. STUART died at his residence, King-street, Woolwich, on April 13th last, aged sixty-seven years. He was the surgeon to the Marine Society's ship *Venus*, the first of their ships stationed at Charlton, and subsequently to the *Warspite*, which replaced the *Venus*. On resigning the appointment in 1867 he received a very handsome and flattering testimonial from the captain, officers, and boys. Dr. Stuart was also surgeon to the Reserve and Dockyard Division of the Metropolitan Police from the commencement of their institution to within the last few years, when, on retiring from active practice, he resigned the appointment. As public vaccinator he was most successful, and on several occasions received the Government grant. On the Contagious Diseases Act coming into operation he was appointed visiting surgeon to the Woolwich and Chatham and London Lock Hospital. He practised in Woolwich with great success for nearly forty years, and was the senior medical man of the town. Prior to that time he had practised in Staffordshire for nearly three years. His practice was one of unusual extent and involved continued labour both by day and night. By his unfailing skill and conscientious impartiality to all his patients, both rich and poor alike, joined to a character of integrity and uprightness, and by the amiable urbanity and benevolence of his disposition, the late Dr. Stuart won for himself the respect and esteem of all whose privilege it was to know him. This was evinced in a remarkable degree at his funeral, which took place on the 21st April at Charlton Cemetery. Throughout the town closed shutters and drawn blinds were almost universal, and a large crowd of all classes followed, both on foot and in carriages, and thronged the road through which the funeral *cortège* passed. Another still larger one was waiting at the cemetery, all showing by their tearful faces and floral offerings gratitude for the past and grief for the loss which had been sustained. The cause of death was paralysis. On December 5th last he had a slight attack in the right side, compelling him for a time to keep to his bed. His old friend Dr. Wilks, of Grosvenor-street, saw him several times, but although he was soon able to leave his bed he never really rallied, and on Easter Sunday his useful life was brought to a close. The grave holds his remains, but his memory will long live with those whose sufferings his skill and kindly sympathy relieved and solaced.

ALFRED MARKHEIM, M.D. PARIS.

WE have to record for his friends in the medical brotherhood the sad loss which it has sustained in Dr. Alfred Markheim, who succumbed in his thirty-ninth year to pulmonary disease at Sorrento on March 11th. Of him it may be said that, though his natural term of life was short, yet he made it long by the memory he has left of himself in the hearts of those who loved him. Those who knew Dr. Alfred Markheim will remember with what gentleness and fortitude he overcame his own cares and sufferings to minister to the sufferings of others; an invalid himself, and fully conscious of the shortness of the respite allowed in his own case by an incurable disease, yet ever ready to anticipate the call of a fellow-sufferer, and rise from his own bed of sickness to relieve pain, soothe anxiety, and administer not only medicine but comfort. In 1870–71 his devotion and activity found suitable employment in the ambulances at Sedan and around Metz, and afterwards in the "Ambulances de la Presse" in Paris during the Commune. It has been said that courage on the battle-field is nothing but the fear of betraying one's natural cowardice. The surgeon's courage is quite different; it is the courage of the man who can care enough for his fellow-men to forget himself. This was illustrated by Dr. Alfred Markheim's conduct in the ward of which he had charge at the Trocadéro, one of the spots most heavily visited with bombardment by the guns of the regular army at Mount Valerian. Wherever help was required he never paused to think of danger. The French Ministry of War showed its recognition of his services by conferring on him the distinction of the Legion of Honour; but he never sought any other distinction but that of being remembered and valued by his friends.

DR. JAMES DAVY RENDLE.

DR. RENDLE, who was medical officer of the Brixton Convict Prison for many years, died recently at his residence, Clapham-park. The deceased gentleman was in his fifty-seventh year, received his professional education at St. Bartholomew's Hospital, became M.R.C.S. England in 1846, M.D. St. Andrews in 1862, and was for some time house-surgeon of St. Bartholomew's. He contributed several papers to the medical journals; also, an account of an aneurism of both popliteal arteries treated successfully by pressure of both femorals to the St. Bartholomew's Hospital Reports (vol. viii.)

THE LATE DR. MURCHISON.

A PRELIMINARY MEETING, composed chiefly of the members of the Edinburgh University Club, was held on Thursday afternoon, at the residence of Mr. Lister, 12, Park-crescent, for the purpose of considering the advisability of perpetuating the memory of the late Dr. Murchison in some fitting manner. It was resolved that a general meeting be called to discuss the question, and this meeting will be held on Thursday next, the 5th of June, at Willis's Rooms, at five o'clock. Dr. Dyce Duckworth and Dr. Farquharson were appointed joint secretaries, and Dr. Potter treasurer, *pro tem.* All definite arrangements were reserved for discussion at the general meeting, which, we may hope, will be numerously attended. Among those present on Thursday were, besides the above-named, Mr. Van der Byl, Deputy Surgeon-General Mackinnon, Mr. Day, Dr. Priestley, Mr. Hill, Mr. Harry Leach, the Rev. Dr. Cosmo Gordon, &c.

PARLIAMENTARY PROCEEDINGS.

HOUSE OF LORDS.

Tuesday, May 27th.

DISQUALIFICATION BY MEDICAL RELIEF BILL.

In committee on this Bill,

The Duke of RICHMOND and GORDON moved an amendment, which he said was adopted from 25 and 26 Vic., cap. 83, sec. 6, an Act applying to the fever hospitals attached to Poor-law Unions in Ireland. A principle of the Poor Law was that those who received parish relief should not possess the franchise, but under that Act a person who had obtained medical relief in a Union fever hospital could ask to repay the guardians the cost of that relief, and if he did so the fact of his having received it did not deprive him of electoral rights.

Lord ABERDARE said he had given notice of an amendment which he thought would be a better one than the noble duke's. His amendment was that the person who received medical relief should not be deprived of the franchise unless the guardians had demanded the repayment of the cost of the relief and the person relieved had refused to comply with that demand.

The Duke of RICHMOND and GORDON said that if the amendment were agreed to, and the words "on demand" were inserted, boards of guardians would be brought into connexion with political questions for the first time since 1832. He could not find out that there was any great demand from the public for the proposal of the noble lord, and he should therefore oppose it.

Earl FORTESCUE thought they were in danger of more and more pauperising the population, and he congratulated the Lord President on having at length made a stand.

Lord ABERDARE withdrew his amendment, and the Bill passed through Committee.

HOUSE OF COMMONS.

Thursday, May 22nd.

THE LUNACY LAWS.

Mr. CROSS, in answer to Mr. Dillwyn, said the Lord Chancellor would be very glad to introduce a Bill to amend the Lunacy Laws, but he was waiting till some progress had been made in the measures already before the House.

Tuesday, May 27th.

THE SALMON DISEASE.

Captain HOME asked the Secretary of State for the Home Department whether his attention had been drawn to a destructive disease extensively prevalent during this and last year among the salmon of certain rivers in England and Scotland.

Mr. CROSS said the question was a very serious one, and it might perhaps be convenient to hon. members to know that he had caused samples of the diseased fish to be placed in the hands of the librarian of the House. The inspectors of fisheries would undoubtedly have their attention directed to the subject, and an efficient inquiry into the causes of the disease would be instituted.

THE ZULU WAR.

Sir W. LAWSON asked the Secretary of State for War whether he was now able to state the total number of officers, non-commissioned officers, and men respectively of the Imperial Forces and of the Native Contingent who had died in South Africa from the date of the declaration of war against Cetawayo up to the present time.

Colonel STANLEY said it would appear from the returns which he had received up to the 20th inst. that the loss among the forces under Lord Chelmsford's command amounted to 1186 men killed, while 86 deaths had occurred from disease. He could not reconcile those figures with others, but he gave them for what they were worth, and hoped before long to be able to furnish the House with more detailed information.

Medical News.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.—The following gentlemen, having passed the required examination for the diploma, were duly admitted Members of the College at a meeting of the Court of Examiners on the 22nd inst.:—

Chaffey, Wayland Charles, Clapham.
Cresswell, John Charles, Bromsgrove.
Dale, Frederick, B.A. Cantab., York.
Edwards, James, Bala, North Wales.
Vaisey, Thomas Frederick, Lechlade, Gloucestershire.
Wilkins, H. G. Gastrill, Ealing.

Of the 63 candidates examined on May 20th, 21st, and 22nd, 33 passed to the satisfaction of the Court and obtained their diplomas; 9 passed in Surgery, and when qualified in Medicine will be admitted Members; the remaining 21 failed to reach the required standard, and were referred for six months' further professional study. Thirteen candidates who passed in Surgery at previous examinations, having subsequently obtained medical qualifications recognised by the College, were also admitted Members.

The following gentlemen passed the first part of the Professional Examination for the Fellowship at meetings of the Board of Examiners during the week:—

Edwin Worts, Guy's Hospital; John Spark and Arthur Jackson, St. Bartholomew's Hospital; T. Law Webb, Birmingham; John Johnson, Melbourne, Australia; J. R. Wynn Webb, St. George's Hospital; T. Preston Lewis, University College and Edinburgh; Edmund H. Howlett, King's College; John Hopkins, University College; Henry Hoole, Charing-cross Hospital; Stephen H. Fisher, Charles E. Jennings, and Edwin H. Fenwick, London Hospital; James E. Lane, St. Mary's Hospital; Geo. F. Gubbin, Westminster Hospital; Frederick R. Walters, St. Thomas's Hospital; David Collingwood, Liverpool and University College; F. W. D. Fraser and Benjamin Wainewright, Edinburgh; Dudley C. Trott and John W. Sanders, Guy's Hospital; Robert H. Firth, University College; James M. Rogers, Middlesex Hospital; Geo. C. R. Bull, St. Mary's Hospital; Ernest Clarke, Cambridge and St. Bartholomew's Hospital; Henry W. Pomfret, Manchester; Henry F. Corbould, Charing-cross Hospital; Robert W. Reid, Aberdeen; Robert Jones and D. D. Day, St. Bartholomew's Hospital; Walter Pearce, St. Mary's Hospital; Charles S. Sherrington, St. Thomas's Hospital; Thomas P. A. Stewart, Edinburgh; J. D. E. Mortimer and John W. Battenham, Westminster Hospital; Edwin H. Holthouse, Cambridge and King's College Hospital; William G. Evans, King's College.

APOTHECARIES' HALL.—The following gentlemen passed their examination in the Science and Practice of Medicine, and received certificates to practise, on May 22nd:—

Davidson, John, Willesdenham, Kilburn.
Phillips, William Alfred, Carlinford Lodge, Sydenham.
Young, Thomas Michael, South Shields.

The following gentlemen on the same day passed the Primary Professional Examination:—

Gervas Miles Wasse, St. Thomas's Hospital; Thomas Kay Whitehead, Owens College, Manchester.

MR. WILLIAM EDWARD HYDE, M.R.C.S. Eng., has been placed on the Commission of the Peace for the borough of Leominster.

THE Registrar-General's return records 1497 deaths in London last week. Of these 194 were referred to diseases of the zymotic class, including 57 from whooping-cough, 55 from measles, and 29 from scarlet fever. The fatality of diseases of the respiratory organs continues to decline, being represented last week by 327 deaths.

DEATH FROM HYDROPHOBIA.—A person named Coyle died in the Richmond Hospital, Dublin, last week, from hydrophobia, having been bitten by a terrier on the 16th of last March.

BOOKS ETC. RECEIVED.

BAILLIÈRE, TINDALL, & COX, London.
Aids to Chemistry. Part III. By A. Semple.
A Manual of Examination of the Eyes. By Dr. E. Landolt. Translated by Dr. S. M. Burnett.
An Introduction to Analytical Chemistry. By Dr. J. Muter.
An Introduction to Pharmaceutical and Medical Chemistry. By Dr. J. Muter.

BLACKIE & SON, London.
A Manual of Organic Chemistry. By H. Clements.

J. & A. CHURCHILL, London.
Lectures on the Diseases of Women. By Dr. C. West.
The Principles and Practice of Gynæcology. By Dr. T. A. Emmet.
The Student's Guide to the Practice of Midwifery. By Dr. D. L. Roberts.
Clinical Remarks on Gleet. By Dr. J. C. O. Will.
Clinical Lectures on Diseases of the Urinary Organs. By Sir Henry Thompson.

HARDWICKE & BOGUE, London.
Evolution, Old and New. By S. Butler, Esq.

KEGAN PAUL & Co., London.
The Human Species. By A. De Quatrefages.

H. K. LEWIS, London.
The Diseases of Infancy and Childhood. By Dr. L. Smith.

LONGMAN, GREEN, & Co., London.
Mechanics. By R. S. Ball.

MACLACHLAN & STEWART, London.
The Dissector's Guide. Part I. By D. J. Cunningham.

MACLACHLAN & STEWART, Edinburgh.
A Manual of Scientific Terms. By Rev. James Stormonth.

MACMILLAN & Co., London.
The Relations of Mind and Brain. By H. Calderwood.

G. J. PALMER, London.
Notes on the Care of the Sick. By A. Brickman.

G. P. PUTNAM, New York.
On Pott's Disease. By Dr. N. M. Shaffer.

SMITH, ELDER, & Co., London.
The Causes and Results of Pulmonary Hæmorrhage. By Dr. R. E. Thompson.
The Notation Case-book. Designed by Dr. H. Veale.
A Manual of Midwifery. By Dr. F. Barnes.

A Contribution to the Hæmatinic Properties of Dialyzed Iron. By Dr. R. Amory.—An Atlas of Histology. By Dr. E. Klein and E. Noble Smith. Part III. (Smith, Elder, & Co.)—The Contemporary Review; May. (Strahan & Co.)—Dickens's Dictionary of London. 1879. (Dickens.)—The Improved District Railway Map of London. (W. J. Adams & Sons.)—Jamaica: a Home for the Invalid and a Profitable Field for the Industrious Settler. By R. Russell and Dr. L. D. H. Russell. (Unwin, Brothers.)—Map of British South Africa. (Wyld.)—An Atlas of Human Anatomy. By R. J. Godlee. Part IX. (J. & A. Churchill.)—Étude Critique sur les Localisations Spinales de la Syphilis. By Dr. L. J. Julliard. (Baillière et Fils, Paris.)—Veröffentlichungen aus dem Königlich Sächsischen Militair-Sanitäts-Dienst. By Dr. W. Roth. (A. Hirschwald, Berlin.)—On the Traumatic Origin of Subfascial, Deep-seated, or Cold Abscess. By Dr. L. A. Sayre. (Trow's Printing Co., New York.)—Neurological Contributions. By Dr. W. A. Hammond and Dr. W. J. Morton. (G. P. Putnam, New York.)—The Proposals for a New University in the North of England. By J. G. Fitch.

Medical Appointments.

BARTLETT, J. H., L.R.C.P.Ed., L.F.P.S.G., has been appointed Medical Officer and Public Vaccinator for the Stamfordham District of the Castle Ward Union, Northumberland, vice Thompson, resigned.

BATTLE, W. H., M.R.C.S., L.S.A.L., has been appointed Resident Accoucheur to St. Thomas's Hospital.

BROOK, T. G., M.R.C.S.E., L.S.A.L., has been appointed Certifying Factory Surgeon for the District of Langport, vice Prankerd, resigned.

BUTLIN, H. T., F.R.C.S., has been appointed Demonstrator of Surgery to St. Bartholomew's Hospital, vice Marsh, resigned.

DALLAWAY, J. W. D., L.R.C.P.Ed., M.R.C.S.E., has been appointed a Resident Clinical Assistant to the Hospital for Consumption and Diseases of the Chest, Brompton, vice Shann, whose appointment has expired.

DAVIES, D. S., M.R.C.S., L.S.A.L., has been appointed Assistant House-Physician to St. Thomas's Hospital.

HARVEY, Mr. S., has been appointed Public Analyst for the Borough of Margate, at 10s. 6d. per analysis.

HASLAM, W. F., M.R.C.S., L.S.A.L., has been appointed House-Physician to St. Thomas's Hospital.

HAVILAND, A., M.R.C.S.E., has been reappointed Medical Officer of Health for the Brackley, Hardingstone, Market-Harborough, Newport-Pagnell, Northampton, Oundle, Thrapston, and Wellingborough Rural, and the Hardingstone and Oundle Urban Sanitary Districts.

JONES, A. E., M.D., M.R.C.S.E., has been appointed Honorary Assistant-Surgeon to the Royal Eye Hospital, Manchester.

LOVEROCK, R. G., L.K.Q.C.P.I., L.R.C.S.I., has been appointed Medical Officer, Public Vaccinator, &c., for the Ballyjamesduff Dispensary District of the Oldcastle Union, co. Meath, at £130 per annum and fees, and £15 per annum as Medical Officer of Health, vice Lough, resigned.

MACDOUGALL, A. R., M.B., C.M., M.R.C.S., has been appointed House-Surgeon to the Royal Hospital for Sick Children, Edinburgh, vice Hay, whose term of office has expired.

MAYBURY, L., M.D., has been appointed Medical Officer for the Railway District of the Portsea Island Union, vice Stickland, resigned.

O'BRIEN, D., L.R.C.P.Ed., M.R.C.S.E., has been reappointed Medical Officer of Health for the North Sub-district of the Axminster Rural Sanitary District, at £25 for one year.

O'MEARA, F. A., L.R.C.P.Ed., L.R.C.S.Ed., has been reappointed Medical Officer of Health for the South Sub-district of the Axminster Rural Sanitary District, at £25 for one year.

PILGRIM, F. J., L.R.C.P.Ed., L.R.C.S.Ed., has been appointed Second Assistant Medical Officer to the York Friendly Societies Medical Association.

RUDKIN, G. M. A., L.K.Q.C.P.I., L.R.C.S.I., has been appointed Visiting Surgeon to Dunnington House Private Asylum, near York, vice North, resigned.

SMITH, R. P., M.R.C.S., L.R.C.P., has been appointed Senior Assistant House-Physician to St. Thomas's Hospital.

TAYLOR, G., M.B., C.M., has been appointed Medical Officer and Public Vaccinator for the Borrowby District of the Northallerton Union, vice Gray, resigned.

WALL, Mr. G. B., has been appointed a Resident Clinical Assistant to the Hospital for Consumption and Diseases of the Chest, Brompton, vice Young, whose appointment has expired.

WILLIAMSON, J., M.A., M.R.C.S., L.R.C.P., has been appointed Assistant House-Surgeon to St. Thomas's Hospital.

WINGFIELD, Mr. J. L., has been appointed Registrar to the Adelaide Hospital, Dublin, vice Franklin, whose appointment has expired.

Births, Marriages, and Deaths.

BIRTHS.

DUKE.—On the 24th inst., at Cornwall-road, Westbourne-park, the wife of George Amos Duke, M.R.C.S.E., of a son.

HOFFMAN.—On the 22nd inst., at Pulham, the wife of Henry W. Hoffman, M.B., of a daughter.

KESTEVEN.—On the 26th inst., at Holloway-road, the wife of William Henry Kesteven, M.R.C.S.E., of a daughter.

LEE.—On the 27th inst., at Savile-row, the wife of Henry Lee, F.R.C.S.E., of a daughter.

McNAUGHTAN.—On the 25th inst., at 3, Queen's-square, Blackpool, the wife of Thomas McNaughtan, M.D., of a daughter.

MARRIAGES.

FRENCH-MULLEN—O'CALLAGHAN.—On the 22nd inst., at Booterstown Parochial Church, by the Very Rev. Canon Farrall, P.P., assisted by Fathers T. Fagan and J. Murray, Dr. St. Lawrence French-Mullen, M.D., Surgeon, Royal Naval Hospital, Malta, to Margaret, daughter of the late Richard William O'Callaghan, of Deepwell, Blackrock, co. Dublin.

LAWRENCE-HAMILTON—JESSEL.—On the 26th inst., at the St. Petersburgh-place Synagogue, by the Rev. Dr. Hermann Adler, assisted by the Rev. Mr. Singer and the Rev. Mr. Haines, J. Lawrence-Hamilton, of 34, Gloucester-terrace, Hyde-park, eldest surviving son of the late Laurence Levy, Esq., to Mary Theresa, only daughter of Edward Jessel, Esq., B.A., Barrister-at-Law, of Gordon-square and Bushey, Herts. No cards.

DEATHS.

DE SANCTIS.—On the 14th ult., at sea, on the passage from the Gold Coast to England, Luigi de Sanctis, M.B., aged 27.

ENGLISH.—On the 22nd inst., at Thurloe-place, South Kensington, Thomas English, M.D., aged 67.

FERGUSON.—On the 21st inst., at Blackburne-place, Liverpool, James Chambers Ferguson, M.B., aged 71.

FROST.—On the 27th inst., at Newcastle-on-Tyne, Samuel M. Frost, M.D., aged 88.

FRYER.—On the 12th inst., at Sherburn, Yorkshire, Charles Fryer, L.K.Q.C.P.I., aged 40.

GENTLEMAN.—On the 26th inst., at Ballyhorgan, co. Kerry, John Kittson Gentleman, L.R.C.P.Ed., aged 31.

GROSS.—On the 30th ult., at Gibraltar, John Edward Gross, M.R.C.S.E.

HIRD.—On the 20th inst., at Bramshott, Hants, James Hird, M.R.C.S.E., F.S.A., aged 38.

LEESE.—On the 19th inst., at Camden-road, George Macartney Leese, M.R.C.S.E., aged 68.

MACNAB.—On the 21st inst., at Skipton, William MacNab, L.R.C.P.Ed., aged 45.

POLLARD.—On the 20th inst., at 55, Milnrow-road, Shaw, near Oldham, John Henry Pollard, L.S.A.L., aged 34.

SMITH.—On the 19th inst., at Clevedon, Alfred Smith, M.R.C.S.E., aged 65.

SMITH.—On the 26th inst., at Forfar, Andrew Robertson Smith, L.R.C.S.Ed., late Staff Surgeon-Major, Army.

SWEETNAM.—On the 22nd ult., at Akyab, British Burmah, Michael Sweetnam, M.D., Surgeon, Madras Army.

TOMS.—On the 27th inst., at Plymouth, Philip Toms, Ext. L.R.C.P.L., F.R.C.S.E., Surgeon R.N., aged 79.

N.B.—*A fee of 5s. is charged for the insertion of Notices of Births, Marriages, and Deaths.*

METEOROLOGICAL READINGS.

(Taken daily at 8 a.m. by Steward's Instruments.)

THE LANCET OFFICE, May 29th, 1879.

Date.	Barometer reduced to Sea Level, and 32° F.	Direction of Wind.	Wet Bulb	Dry Bulb	Solar Radia in Vacuo	Max. Temp Shade	Min. Temp	Rain fall.	Remarks at 8.30 A.M.
May 23	30·14	N.W.	47	52	70	55	45	0·20	Cloudy
„ 24	30·23	N.E.	49	55	90	69	45	0·03	Cloudy
„ 25	29·87	S.W.	50	51	80	60	49	0·43	Raining
„ 26	29·88	W.	50	55	98	59	42	..	Cloudy
„ 27	29·62	S.E.	50	52	80	60	48	0·15	Raining
„ 28	29·61	N.E.	49	50	96	61	46	0·27	Overcast
„ 29	29·62	S.W.	48	52	92	60	45	1·50	Cloudy

Notes, Short Comments, and Answers to Correspondents.

Justice.—1. The answer is doubtful. Glenn says: "A registered practitioner may maintain an action for professional services rendered by an unregistered assistant." But we should doubt the success of an action in which professional attendance consisted of nothing but the services of an unqualified assistant.—2. Certainly not.—3. *Beati possidentes.* The process of getting such a fee improperly given might be difficult and costly; but an unregistered person, having no medical status, can clearly not give medical evidence.

J. F. (Newcross) will find in THE LANCET of July 21st, 1877, a full description of the various kinds of ice-making machines in use at that time.

AN APPEAL.

To the Editor of THE LANCET.

SIR,—The following case will, I hope, commend itself to your powerful notice and to the sympathy and generosity of the profession.

Thos. Jas. Biddle, surgeon, of Yately, Hants, died suddenly on the 17th inst. His income for many years past from all sources had not reached £150 a year. He had sunstroke in India, and was invalided by a Medical Board many years ago, since which time he has been unfit for any continuous work. As assistant-surgeon in the army, he served on the medical staff in the Crimea during the winter of 1854 (being attached to the 49th Regiment at Inkerman), and at the hospital at Scutari, January and February, 1855, when he was ordered home with 250 sick and wounded. (Medal and clasp for Sevastipol and Turkish medal.) Served with the 8th Regiment through the whole of the Indian mutiny (including the outbreak at Jullundar, the surprise by night of the Fort of Phillour, the siege and assault of Delhi), including all the sorties previous to the final capture; was present at the capture of the Cashmere Gate, the subsequent six days' fighting in the city, and the capture of the Burn Bastion; served with Brigadier Hale's column at the capture of the Fort and Town of Sandee, and the other operations until the final pacification of the country (medal and clasp). He leaves a widow, three daughters, and one son almost penniless.

The Rev. H. Sumner, Vicar of Yately, Farnborough, Hants, will be happy to receive and acknowledge any sums which may be forwarded.

I am, Sir, your obedient servant,

C. J. DENNY, M.R.C.S. Eng.

Blackwater, Hants, May 28th, 1879.

A CORRECTION.

A STATEMENT in our last week's issue, to the effect that "the medical officership of Brixton Prison is now vacant," is erroneous. Mr. J. H. Parker Wilson, late Assistant-Surgeon to the Woking Prison, was appointed to that office on January 1st last. We may add that the surgeoncies to H.M. prisons have invariably been filled up, as they become vacant, by the appointment of the senior assistant-surgeons.

CHRYSOPHANIC ACID IRRITATION AND ITS STAINS.

To the Editor of THE LANCET.

SIR,—In a case of chronic eczema (after several remedies had failed) I used the ordinary chrysophanic-acid ointment. The first application gave relief, and caused only a brown discoloration; the third application was followed by the most violent irritation, extensive erythema, and œdema, which, however, I am glad to say, has passed away, as also the eczema. The sudden and somewhat startling appearance of these unlooked-for symptoms gave me some anxiety for a day or two; but I now feel amply rewarded by the disappearance of a most persistent and protracted eruption, and, with the exception of an occasional creeping and tingling sensation, I consider my patient relieved of a most painful and annoying disease. I cautioned my patient to carefully protect his clothes whilst using the ointment; but, to his great chagrin, he finds sheets and shirts alike blackened by the indelible stains of this potent and efficacious remedy. Is there any known reagent which will remove the stains without damaging the material?

Yours faithfully,

Birmingham, May, 1879. E. G. S.

Mr. Frederick D. Dyan.—The marriage of first cousins is not recommended if there be great similarity of physical or mental qualities. The offspring of such a union may be healthy and strong; but if there be any latent ancestral taint or bias, the concentration of hereditary force is likely to awaken it. In searching for evidence of such taint or bias, it is necessary to bear in mind that properties or qualities may be transmitted although they slumber in alternate generations, or sometimes during two successive periods.

Crecy.—Apply to Mrs. Wardroper, St. Thomas's Hospital.

SHAKESPEARE AND THE CIRCULATION OF THE BLOOD.

To the Editor of THE LANCET.

SIR,—Dr. Cosmo Logie, in his letter on the above subject in THE LANCET of last week, wonders whether the illustrious Harvey had studied Shakespeare deeply, and quotes from the "Second Part of Henry VI.," Act III., Scene II., the speech of *Lord Warwick* on beholding the dead body of Duke Humphrey of Glos'ter, as language displaying a most marvellous knowledge of the heart's real action.

In the knowledge shown by our immortal bard there is a proof that, like all the discoveries made by man, that of the circulation of the blood has not been exempted from its foreshadowings. Solomon, Hippocrates, Aristotle, Galen, Fabricius ab Aquapendente, Mondino, Servetus, Realdus Columbus, Cesalpino, have all and each been credited, in degree, with partial and progressive knowledge of the circulation; by each an advance was made on the ladder of discovery; but to Harvey was reserved the marvellous quality of intuitive induction, by which he earned the honour of bridging the chasm which separated the certain from the uncertain, and of giving to the world in all its fulness that immortal discovery of the circulation, the most extraordinary which has been made in physiological science.

Similar foreshadowings have preceded other discoveries. The torpedo and the screw may be said to have been foreshadowed by Ben Jonson in his "Staple of News"; the law of gravitation by Shakspeare in his "Troilus and Cressida"; telegraphy by Leo, Archbishop of Salonica (888); the late discovery of the two satellites revolving about Mars by Professor Asaph Hall, by the astronomers of Laputa in Dean Swift's "Gulliver's Travels"; steam by the Egyptians; armour-plated ships by one of the Maltese galleys sent, by the Order of Malta, to the assistance of the Emperor Charles V. of Germany in his expedition against Barbarossa; the ram by the old rostrum; the revolver, the mitrailleuse, the breech-loader, with many others, have likewise had their foreshadowings.

The following extract from the work of Rabelais, who died A.D. 1553 (a physician and likewise a monk), shows a foreshadowing knowledge of the circulation of the blood:—"Contemplez la forme d'un homme attentif à quelque estude, vous voirez en lui toutes les artères du cerveau bandées, comme la chorde d'une arbaleste, pour lui fournir dextrement esperits suffisants à emplir les ventricules du sens commun, de l'imagination et appréhension, de la ratiocination et résolution, de la mémoire et recordation; et agilement courrir de l'un à l'aultre par les conduicts manifestes en anatomie, sus la fin du rets admirable, onquel se terminent les artères, lesquelles de la senestre armoire du cœur prennent leur origine, et les esperits vitaulx affinent en longues ambages, pour estre faicts animaulx."—Pantagruel, l. iii., c. xxxi.)

Yours faithfully,

Dover, May, 1879. JAMES DONNET, M.D.

To the Editor of THE LANCET.

SIR,—Other quotations from Shakespeare's works referring to the circulation of the blood may interest your readers.

In "Julius Cæsar," Act II., Scene I., *Brutus* speaks:

"You are my true and honourable wife;
As dear to me as are the ruddy drops
That *visit* my sad heart."

Again, in "Measure for Measure," Act II., Scene IV., says *Angelo*:

"Why does my blood thus muster to my heart?"

Yours faithfully,

York, May 24th, 1879. HOWARD NANKIVELL, M.R.C.S.

MISS DE LISLE ALLEN, daughter of the late Dr. de Lisle Allen, has announced her morning concert for to-day (May 31st), at which some of the leading *artistes* of the musical profession will appear. We trust that this undertaking will meet with every success.

Mr. Francis Hudson.—We cannot name a physician. Our correspondent should consult his usual medical attendant.

LAXATIVE BREAD FOR CONSTIPATION.

To the Editor of THE LANCET.

SIR,—I have lately had bread prepared as follows, and found it most useful in ordinary constipation and as a laxative in piles:—Coarse Scotch oatmeal, whole wheaten flour, coarse (not Chapman's fine) ordinary flour, of each equal parts. The bread can be lightened by yeast, or, to a two-pound loaf, one tablespoonful of baking-powder, made of four ounces of bicarbonate of soda, three ounces of tartaric acid, one pound of ordinary flour, rubbed well together, and kept dry in a tin or well-corked bottle. The bread keeps well, and a two-pound loaf will be sufficient for a week, taking a portion once or twice a day in conjunction with ordinary bread.

Your obedient servant,

Anerly, S.E., May 13th, 1879. W. H. TAYLER, M.D.

A Successful Candidate.—At the primary examination for the Fellowship of the College of Surgeons, which has just been brought to a close, there were sixty-five candidates. The following were the examiners at the four tables: Messrs. John Wood and W. Morrant Baker, Henry Power and Walter Rivington, Christopher Heath and T. Pickering Pick, J. W. Hulke and Arthur E. Durham. Mr. Timothy Holmes was the Chairman.

Dr. J. C. Baker.—The device is impudent; but it does not amount to a violation of the Medical Act.

Mr. Durbidge should consult the Medical Directory.

THE M.D. OF BRUSSELS.

To the Editor of THE LANCET.

SIR,—In the belief that it may interest some of your readers, especially those who are desirous of obtaining the above degree, we send you a brief account of the manner and matter of our recent examination for the same, in which we were successful.

We will preface our remarks by stating that by a recent decree the examinations are not now held as heretofore at uncertain intervals, determined by circumstances, but at fixed periods, which take place on the first Tuesday in November, December, February, May, and June. We would recommend those about to proceed to Brussels to do so *vid* Dover and Calais, and, where a slight increase of expense is not an object, return through Antwerp and Harwich. It is advisable to go to the University as soon as practicable on arrival, and pay the fees, as priority in this respect determines the order in which the candidates are admitted—a matter of moment where time is of consequence.

Feeling that we must not occupy your space with a detailed account of the examinations, we wish briefly to state that they extended over five consecutive days, and were of a most severe and crucial character, and considerably more searching and comprehensive than any we had undergone in England; the operations on the dead body and surgical and regional anatomy, together with dissections, being especially trying on candidates, some of whom had obtained their surgical diplomas twelve years since. The examiners make no allowance or entertain any excuse for the deficiencies of a candidate; and if he fails to satisfy them he will most certainly be "ploughed," irrespective of grey hairs or long services, as we had occasion to witness last week. We ascertained that twenty-eight British medical men presented themselves at the Brussels University in the year 1878, and of these fourteen were rejected in one or other of the three examinations.

If you, Sir, will be good enough to give publicity to these facts, we feel it may be the means of making future candidates more careful as to the degree of their preparedness, and thus of upholding our professional position among foreigners.

In conclusion, we wish to say that M. James, the Professor of Latin in the University, who interpreted for us at the examinations, did us good service, and we were much impressed by his culture and intelligence, and general kindness and amiability.

Should any of your readers wish for further details of the examinations, we shall be happy to supply them.

We are, Sir, yours faithfully,

J. BERESFORD RYLEY.
May, 1879. H. G. WALKER.

A. C. H.—The Annales d'Oculistique and the Archiv f. Augenheilkunde, which last is published in German and English by Knapp in New York, and Hirschberg in Berlin. Apply to Williams and Norgate, Henrietta-street, Covent-garden.

M. O. T. should communicate with the analyst.

"FREAK OF NATURE."

To the Editor of THE LANCET.

SIR,—Will you allow an outsider to offer some suggestions respecting the alleged "freak of nature" in a hen at Llanferras, reported by "R. E. A. D." in your issue of the 10th inst.

Being an amateur physiologist and student of comparative anatomy, as well as a keeper of domestic fowls and a close observer of their habits, I give the following as an explanation of this "novel occurrence":—Hens, and especially young ones, often become "egg-bound," or unable to part with their eggs, and will sometimes remain in that state for a day or two. A little lard or other fat mixed with their food will soon set them right.

Probably the case in question was an unusual or aggravated form of being "egg-bound," and, as nothing seems to have been done to relieve the hen, it would appear that the eggs became permanently wedged in the oviduct, and the heat of the hen's body would partially develop the chickens, just as it would have done if the hen had been sitting on the eggs. Further advancement would, no doubt, be stopped through the air not being able to permeate the shells. The first egg blocking up the oviduct, a second would then be fully formed, and others behind them in different stages of development, their *further* development being arrested by the first two blocking the natural outlet. This would account for the apparent fatness of the hen. It therefore appears to have been no more a "freak of nature" than would be the case of a viviparous animal that, owing to straitness of the vagina or malformation of the pelvis, was unable to bring forth its young when fully formed.

I am, Sir, yours faithfully,

J. B. HARRISON, Postmaster.
District Post-office, Ulceby, May 20th, 1879.

THE CLINICAL SOCIETY:—A CORRECTION.

IN the report of the meeting of the Clinical Society of London for the 25th ult., p. 668, the name of *Oertel* was inadvertently misprinted as "Brohl"; and in the discussion on his paper, Dr. Semon meant to be understood that he did *not* assent to the theory raised concerning his case that the paralysis was of centric origin, but that, on the contrary, he himself held quite an opposite view.

MEDICAL MEN AND THE CLERGY.

To the Editor of THE LANCET.

SIR,—Like "M.B.," I, too, have had "extensive experience in general practice in both England and Scotland"; but, unlike him, my experience leads in quite an opposite direction to the assertion, "that among medical practitioners in first-rate practice" it is a long established and universally acknowledged custom *not* to charge nor to accept fees from clergymen. My own father was a clergyman in Scotland, and was attended and *charged* by one of the most enlightened and successful practitioners in the country. This was years ago; but at present I have near relations in the Church in both England and Scotland, and they also pay their doctor's bill like other people. Whatever obtains in the neighbourhood where "M.B." is practising, the absurd custom he refers to is certainly not recognised in the Midlands, as I myself and all my *confrères* invariably send in yearly bills to our clerical patients, and not in one instance have I known such to be called in question on the plea of breach of custom. It is all very well for a consultant like Sir Wm. Gull (who, I understand, gives advice of this kind to the clergy), or for a general practitioner with only one or two curates to look after. But what of our brethren in cathedral towns? Are they, too, to ignore the financial element? Though not practising in a town at all, I attend professionally no fewer than thirteen clergymen and their families, some of them six miles from my surgery. One of these is an honourable, two are squires, and others of them, though not holding such exalted rank, keep their carriages, their hunters, and otherwise live in the style of a high social position. Besides the loss in a financial point of view, I can scarcely see my way to insult such patients by offering them eleemosynary aid in the shape of gratuitous medical attendance. Such a system has no reason, no sense in it, no analogue in other phases of social life, and, besides, in a large proportion of instances (certainly in this district) the clergymen are better off than the doctors. Of course, when any patient is a poor struggling curate with a large family, I always offer my services gratuitously; but I do this in the way of individual kindness, not in the way of customary claim on my already heavily handicapped profession.

Besides these respected members of the Church, I have also on my books four or five dissenting ministers, not to mention those *quasi*-ministers of the "Truth" who divide their time by preaching on Sunday and standing behind the counter on week days. Are these also to be attended? Running the risk of being called, like "Lancaster Joyce," avaricious, I maintain that such a system is uncalled for—is, in short, absurd in the extreme. The idea of any medical man entering into a "touting" arrangement with the clergyman is, I think, a coarse one; but there is a deal of human nature in both professions, and when the doctor gives his services he naturally looks for his *quid pro quo*, if not in the concrete coin of the realm, in some less satisfactory yet definite way.

Yours truly,

May, 1879. PITCHLEY.

To the Editor of THE LANCET.

SIR,—I scarcely think that a M.B. of so great experience as your correspondent can have failed to discover the advantage of securing the good offices of the clergyman, which he effectually does by his gratuitous service. Unhappily I have an instance before me where such is rendered to the very evident advantage of the charitable individual. So desirous is the recipient to recoup his benefactor that he makes a special request to his curates when taking up their residence in the town to obtain the services of *his* medical man if requiring help, thereby securing to him the whole clerical interest, which, if not reprehensible on the part of the medical practitioner so obtaining it, may be aptly designated "a very clever dodge" to get himself favourably placed before the public.

Yours &c.,

May, 1879. MEDICUS.

To the Editor of THE LANCET.

SIR,—Surely to argue that the clergy, *as clergy*, have no desire, and are not expected, to pay for a medical man's services, is preposterous. The facts are all the other way, so far as my experience goes. A. B. is a vicar, with £500 a year, a wife and family; or an unmarried curate, with £150 a year. C. D. is an incumbent or curate, with £150 a year, a wife and family. Surely the two cases are not to be put on the same footing. Any professional man of right feeling would, I should think, be only too happy to render his services gratuitously in the latter case; whilst in the former, I maintain, he would not be justified in doing so, either in justice to himself or to his professional brethren in the same locality.

I remain, Sir, yours &c.,

May, 1879. S. A.

A QUERY.

To the Editor of THE LANCET.

SIR,—A gentleman, who has lately returned from Spain, noticed that the women had the peculiar habit of constantly leaning on their elbows, and asked me if I knew whether they were subject to the enlargement of the "bursa" over the olecranon, which is so common in the bursa patellæ of the housemaid. If such is the case, would any of your readers inform me in your next number? Yours &c.,

Harrow-road, May, 1879. H. B. RUNNALLS.

Malcolm will do wisely to examine the requirements specified in the Students' Number of THE LANCET, September 14th, 1878, and consider the preliminary examinations which must be passed before the medical curriculum can be even commenced.

Mr. W. S. Dines.—Any hospital surgeon can treat the case. We cannot name a particular practitioner.

Brussels.—We do not know of any such works.

SANITARY STATE OF PENZANCE.

To the Editor of THE LANCET.

SIR,—The Sanitary Committee of this town have observed Mr. Renton's letter in your issue of the 17th instant, and accept the expression of his regret at the inaccuracies in his former communication under the signature of "G. R." They observe, however, that he still considers his statement as to the alleged "apathy" of the authorities to have been justified on the ground that at the time his letter was written "nothing had been done to remedy the supposed cause of the fever." Now, in this again Mr. Renton must be relying on untrustworthy information, as he would have discovered if, instead of hastily writing to your influential and widely circulated journal on the mere information of a lady who was excited in consequence of the illness of her relatives, he had applied for information to the authorities. He would have found that they were quite alive to the exigencies of the case, and were taking all necessary precautions.

I have to thank you on the part of the Committee for having complied with their request in eliciting the name of your correspondent, and trust that the temporary damage done to the town by his hasty communication will be removed by the explanations which have taken place.

I am, Sir, your obedient servant,

Penzance, May 27th, 1879. THOS. CORNISH, Town Clerk.

Mr. W. Larner.—The "specialty" referred to is not recognised by the profession. Any surgeon will do all that is required.

Dr. McCall Anderson.—We shall be obliged.

Mr. Alex. Ogston.—Yes.

A GRIEVANCE: A VERY GREAT ONE.

To the Editor of THE LANCET.

SIR,—I hope you will find space in your next issue for the following facts.

I was called on Sunday last to see a girl who had taken poison. I took a stomach-pump, emetics, and an enema syringe, and hurried to her home. When I arrived I found that she had taken half a packet of "Vermin Killer," and, in spite of all I could do, she died in about two hours after taking the poison. There was an inquest on Tuesday, and, rather to my surprise, when I returned home after my morning's round, I received a verbal message (from the policeman through my wife) that I was to attend the inquest. I may also state that the policeman in charge of this case had a written order from the coroner to have all necessary witnesses and jury there at the time. I attended as ordered. The coroner seemed rather in a hurry to catch the train; two or three witnesses were called, and a verdict of "Suicide during a fit of temporary insanity" returned. When the coroner came to my name on the list of witnesses, he told the jury they might call me if they wished; but, if so, he should be obliged to pay my fee. The jury decided that it was unnecessary to call me, and so he struck out my name, and would not allow me any fee, after driving two miles and losing two hours.

My object in stating these facts is to warn the medical profession against this kind of treatment.

I remain, Sir, yours faithfully,

Hoyland, Yorks, May 21st, 1879. W. RITCHIE, M.D.

Mr. Peter Higson.—The communication was duly authenticated, or would not have appeared.

Responsum has forgotten to enclose his card.

Mr. F. Baker (Birkenhead) is thanked.

THE DEGREES OF ST. ANDREWS.

To the Editor of THE LANCET.

SIR,—In your issue of the 24th instant you say to your correspondent, "R. C. B.," that "both the University of Durham and that of St. Andrews give degrees, without residence, to practitioners."

Kindly permit me to say that St. Andrews only does so to the extent of *ten* M.D.s each year, and that under special regulations, one of which is that candidates must be at least forty years of age. For the degrees of M.B. and C.M., candidates *must* have the usual residence at some British University, and the number of these degrees is not limited. Such graduates may, after two years, receive their M.D. As, however, most students graduate at their University of study, the M.B. and C.M. degrees are so comparatively rare at St. Andrews that it is not generally known that they exist. These degrees may be taken in *three* examinations, as at other Universities; but, practically, candidates appear for the whole eleven subjects during a three days' examination of eight hours a day. The medical examinations are conducted by the three medical professors of St. Andrews and a Board chosen by the University from amongst the medical lecturers of the Edinburgh school, some of whom are also extra-examiners to the University of Edinburgh.

I am, Sir, yours faithfully,

Edinburgh, May 26th, 1879. L.R.C.P. Edin.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

THE following were the questions on Surgical Anatomy and the Principles and Practice of Surgery submitted to the candidates at the written examination for the diploma of Member of the College on the 16th instant, when they were required to answer at least four, including one of the first two, out of the six questions:—

1. Describe the anatomy of the hip-joint, and the lesions which occur in dislocation of the femur on to the dorsum of the ilium.
2. Describe the anatomy of that region of the abdominal wall which is bounded, below, by Poupart's ligament, and, above, by a horizontal line drawn from the anterior superior spine of the ilium to the median line.
3. A tumour is found in the popliteal space—To what may it be due? How would you proceed to determine its nature?
4. Describe the symptoms, progress, and treatment of a case of extravasation of urine following an injury to the perineum.
5. What local symptoms may accompany and follow a compound fracture of the vertex of the skull?
6. What conditions does the eye present in acute glaucoma? Describe the treatment of such a case.

The following were the questions on the Principles and Practice of Medicine submitted to those candidates on the following day who had not passed in Medicine or obtained a recognised medical licence:—

1. Describe the course and features of measles and scarlet fever, their sequelæ, and the prominent measures of treatment and prophylaxis suitable in each case.
2. Under what circumstances does embolism of a cerebral artery occur? What would be the consequent symptoms, and what would you advise to be done for the relief of the patient?
3. What are the effects of overdoses of the following medicinal substances: Belladonna, digitalis, iodide of potassium, chloral, arsenic, and cantharides? Give their chief pharmacopœial preparations, and their average doses. Write out in full a prescription, for a mixture, for an adult suffering from chronic bronchitis.

TRICYCLES.

To the Editor of THE LANCET.

SIR,—I should recommend your correspondent, "Viator," to send his query to the Editor of *Bicycling Times*, East Temple-chambers, Whitefriars-street, E.C. So far as I can judge, I should say the Challenge tricycle by Singer and Co., Coventry, would, if fitted with extra thick tyres, be most suitable for the roads he describes. It has only one large wheel, and is consequently lighter, and for that reason easier to drive, than one with two. The distance which can be done in a day depends entirely on the rider. A man in good health should be able, after a little practice, to cover thirty-five or forty miles a day without *excessive* fatigue. Should "Viator" get one, he should not attempt to ride more than ten or twelve miles a day for the first few days. He can then gradually increase it as he gets used to his machine. He can place every reliance on Messrs. Singer and Co.'s workmanship. Since last autumn I have ridden one of their bicycles myself over very rough roads, and have never yet had anything give way. I also find it run better than any machine I have had previously.

Yours faithfully,

May, 1879. C. F. W.

To the Editor of THE LANCET.

SIR,—For the information of "Viator," I beg to say that my opinion of a tricycle is most favourable. Before purchasing, I gave careful consideration to the capabilities of different makes, and ended by selecting a machine known as "The Dublin Tricycle." After a year's work, I can say that I am thoroughly well pleased with my choice. A friend has a machine of a different build, with two large (50-inch) wheels, which is a dreadful affair to work. It capsizes, runs away down hill, and comes to a full stop going up hill. A machine with a large driving wheel may go very well and quickly on a perfectly level road; but the work becomes very laborious, and frequently impracticable, when the road is hilly. My "Dublin" has only a 34-inch driving wheel. I can travel eight miles an hour, can ride thirty or forty miles with enjoyment and little or no fatigue, and can work up and down every hill in this hilly part of the country with perfect ease and safety.—Yours obediently,

W. H. S. WESTROPP, L.R.C.S.I.

Lisdoonvarna, county Clare, May 26th, 1879.

CASE OF A REMARKABLE ALBINO.

To the Editor of THE LANCET.

SIR,—A short time since I met with, what to me appeared, so unusual a case that I think it may interest those who pursue ophthalmic subjects if I place it on record.

The ordinary albino, as is generally known, has pink eyes, owing to the absence of black pigment, and hair which is quite white; but in the case I allude to, a girl of eleven years of age, the eyes were pink, accompanied by the usual photophobia, but "the hair was of a bright red colour." She was one of a family of eight children, the father and mother having no peculiarity. Of the other children, a girl aged sixteen, and a boy aged four, had the pink eyes and white hair of pure albinos. One boy had dark hair and eyes, and the remainder had light hair and good eyes both as regards colour and power of vision. Never having met with this combination of pink eyes and red hair before, and it appearing to me so very peculiar, if not unique, I think it should be recorded.

Yours &c.,

May, 1879. W. H. FOLKER, F.R.C.S.